U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 10 September 2007

.....

In the Matter of:

L.P.
Claimant,

v. Case No.: **2004-BLA-05226**

CONSOLIDATION COAL COMPANY,
Employer/Carrier, and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.
.....

Appearances:

Stephen A. Sanders, Esq., Appalachian Citizen's Law Center, Inc., Prestonsburg, KY
For the Claimant

William S. Mattingly, Esq., Jackson Kelly, PLLC, Morgantown, W.V.
For the Employer/Carrier

Before: PAMELA LAKES WOOD
Administrative Law Judge

DECISION AND ORDER GRANTING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* (hereafter "the Act") filed by L.P. ("Claimant") on July 8, 2002. The putative responsible operator is Consolidation Coal Co. ("Employer"), which is self-insured. Benefits are being paid by the Black Lung Disability Trust Fund.[1]

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980, and the regulations amended as of December 20, 2000 are also

[1] The term "Employer" will encompass both the Insurance Carrier and the Employer.

applicable, as this claim was filed after January 19, 2001.[2] 20 C.F.R. §718.2. In *National Mining Assn. v. Dept. of Labor*, 292 F.3d 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected the challenge to, and upheld, the amended regulations with the exception of several sections.[3] The Department of Labor amended the regulations on December 15, 2003 for the purpose of complying with the Court's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all evidence admitted and arguments submitted by the parties. Where pertinent, I have made credibility determinations concerning the evidence.

STATEMENT OF THE CASE

Claimant filed this claim for benefits, his first under the Act, on July 8, 2002. (DX 2).[4] He was examined by the Department of Labor ("DOL") on November 6, 2002.[5] (DX 13). On July 11, 2002 the district director issued a Notice of Claim identifying Employer as the potentially liable responsible operator. (DX 29). On January 28, 2003, the district director issued a Schedule for the Submission of Additional Evidence stating Employer would be liable for payment of any benefits awarded, but that Claimant was not entitled to them. (DX 32). On July 7, 2003, the district director issued a Proposed Decision and Order-Denial of Benefits. (DX 36). The district director found that Claimant had pneumoconiosis arising from coal mine employment, but also concluded that he was not disabled as a result of the disease. *Id*. Claimant filed a letter with the district director on August 4, 2005 asking him to reconsider his decision. (DX 37). The district director complied, and on August 7, 2003 he issued a Revised Proposed Decision and Order-Award of Benefits-Responsible Operator. (DX 38). The district director decided that Claimant was indeed disabled, and that said disability arose from pneumoconiosis. *Id*.

By way of letters filed August 25, 2003 and October 16, 2003, Employer sought review before the Office of the Administrative Law Judges. (DX 39, DX 42). On October 15, 2003, the district director initiated payment of interim benefits. (DX 43). The case was transmitted for a hearing on or about November 3, 2003. (DX 45).

The matter was initially set for a hearing on February 1, 2005 before Administrative Law Judge Gerald M. Tierney in Wheeling, West Virginia, but the case was continued so that Claimant could seek representation. Thereafter, two prehearing motions were filed (a motion to compel filed by the Claimant on December 20, 2005 and a motion for acceptance of post hearing evidence filed by Employer on December 23, 2005), as discussed below.

---

[2] Section and part references appearing herein are to Title 20 of the Code of Federal Regulations unless otherwise indicated.

[3] Several sections were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting was not upheld by the court.

[4] Director's Exhibits, Claimant's Exhibits, and Employer's Exhibits are referenced as "DX", "CX", and "EX", respectively, followed by the exhibit number. References to the hearing transcript appear as "Tr." followed by the page number.

[5] Claimant had previously filed a West Virginia state workers' compensation claim for his breathing problems. (DX 22, DX 23). He was found to have a 20% pulmonary impairment function. (DX 22).

A hearing was held before the undersigned on January 12, 2006 in Charleston, West Virginia. Claimant was the only witness to testify. (Tr. 56-71). Documentary evidence was also offered. First, Director's Exhibits 1 through 47 were admitted into evidence; however, I struck portions of Director's Exhibit 26. (Tr. 46-51). Director's Exhibit 26 was submitted by Employer and contained three interpretations of the September 18, 2002 DOL exam film (by Drs. Paul Wheeler, William Scott, Jr. and John Scatarige). (Tr. 47). Employer's counsel designated Dr. Wheeler's interpretation as rebuttal to the DOL film, and offered the other two for good cause. (Tr. 47-48). I accepted Dr. Wheeler's reading, but struck the other two interpretations.[6] (Tr. 51). Second, with respect to DX 22, which included evidence from Claimant's state workers' compensation claim, I indicated that, to the extent not designated by either party, it was admissible only to the extent it included treatment records; however, as the expert witnesses had apparently relied upon it, I suggested that it could be considered as other evidence. (Tr. 49-51). The evidentiary limitations are discussed further, below. Third, Employer's Exhibits 1 through 5 and 8 were admitted into evidence. (Tr. 75). Employer also offered as Employer's Exhibits 6 and 7, an affirmative medical report from Dr. James Castle and his curriculum vitae respectively. *Id*. Dr. Castle had not previously examined Claimant, and Employer's counsel could not offer any reason for admission other than relevance. (Tr. 76). Therefore, I rejected this evidence. (Tr. 77). Finally, Claimant's Exhibits 1 through 6 were also admitted into evidence. (Tr. 56).

At the hearing, I also addressed the Motion filed by Employer on December 23, 2005 that asked for the acceptance of post-hearing evidence, or in the alternate, a continuance. As part of its affirmative evidence, Claimant offered a December 19, 2005 opinion from Dr. Lenkey. (CX 5). However, the opinion referenced findings relating to a July 2005 chest x-ray, a February 23, 2005 pulmonary function test, a June 7, 2004 CT scan, and a November 18, 2005 pulmonary function test, none of which were of record or designated by the parties.[7] *Id*. At the hearing, Claimant argued that the additional referenced documents were admissible as treatment records and that the references to them should not, therefore, be stricken. (Tr. 34-41). I asked that the record be supplemented with the actual referenced treatment records. (Tr. 41-42). Based on the newly submitted evidence, I allowed the Employer to retake the depositions of Drs. Lenkey, Altmeyer, and Fino. (Tr. 43-44). I asked that these new depositions relate to the newly submitted evidence, but provided that Claimant's counsel would be able to inquire into areas previously covered, as he did not participate in the previous depositions, and Employer's counsel would be able to address any areas opened up by Claimant. (Tr. 44-45).

At the conclusion of the hearing, the record was kept open for 60 days for supplementation as discussed above, with briefs or written closing arguments to be submitted 30 days thereafter, subject to extension by stipulation. Posthearing, under cover letter of June 22, 2006, the transcripts of the depositions of Dr. Robert Altmeyer (taken on April 16, 2006) (EX 9), Dr. Attila Lenkey (with attached treatment records) (taken on May 15, 2006) (EX 10), and Dr.

[6] In its post-hearing brief, Employer argued that it should be allowed to submit another one of the interpretations as a result of the recently decided *Elm Grove Coal Co. v. Director, OWCP*, 480 F.3d 278 (4th Cir. 2007). I will address this argument in greater detail *infra*, but briefly stated, I disagree with that contention.

[7] After discussing the 2001 x-ray, Dr. Lenkey references an arterial blood gas (date not specified); however, it appears that he may have referenced the July 20, 2001 ABGs that are of record (with values truncated) (DX 22). A February 2, 2005 CT scan report was subsequently identified at Dr. Lenkey's deposition (EX 10) but was not apparently referenced in the report.

Gregory J. Fino (taken on June 5, 2006) (EX 11) were filed; they were formally admitted into evidence by my June 27, 2006 Order on Reconsideration (discussed below).

Claimant's Motion to Compel, filed on December 20, 2005, was also addressed at the hearing. Claimant's Motion was marked as ALJ 1, and Employer's response (filed on December 28, 2005), as ALJ 2. (Tr. 7). The Motion related to Interrogatories served by Claimant on November 2, 2005, seeking the number of referrals made and the amount of money paid by Employer to Drs. Altmeyer, Meyer, Fino, Castle, Wheeler, Scott, Scatarige and Binns from 2000 through 2005. (ALJ 1). In its response to Interrogatory 4 (also incorporated by reference as response to Interrogatory 5) served on November 21, 2005, Employer wrote the following:

> RESPONSE: CONSOL objects to this Interrogatory as irrelevant, unreasonable, and over-burdensome. Compiling such data, if even possible, would require hundreds of man-hours just in those cases where CONSOL is represented by the law firm of Jackson Kelly PLLC. The Rules of Practice and Procedure Before the Office of Administrative Law [Judges] do not authorize such a request or require a party to go to such extraordinary effort, which would involve review of hundreds of files in three separate offices. Further, the number of referrals or the amount of money paid to expert witnesses for professional services in black lung cases provides no probative information relevant to the issues to be determined in this claim for Federal Black Lung benefits.

(ALJ 1). Claimant's motion to compel, dated and served on December 9, 2005, was filed on December 20, 2005. (ALJ 1). Employer's response was filed on December 28, 2005. (ALJ 2).

At the hearing, Claimant's counsel agreed to limit the information sought to only those physicians whose opinions were being utilized for the instant case (Drs. Robert B. Altmeyer, Christopher A. Meyer, and Gregory J. Fino). (Tr. 10). I ordered Employer to provide me with specific information regarding the burden it would face in answering the interrogatories. (Tr. 27-28). Employer was given thirty days to respond. (Tr. 30).

What transpired next is best summarized in my Order on Reconsideration dated June 27, 2006:

> Under cover letter of March 16, 2006, which has been marked for identification purposes as ALJ 3, Employer's counsel provided a March 10, 2006 response from CONSOL Energy Inc. (of which Employer Consolidation Coal is a subsidiary) to the Motion to Compel (hereafter "CONSOL's Response.") Although the response was addressed to the undersigned administrative law judge, the only copy received was that forwarded by counsel.
>
> In CONSOL's response, Philip W. Nicholson, Manager – Payroll & Disability Programs, reiterated some of the points made by the Employer's counsel at the hearing, to the effect that Jackson & Kelly was not the only law firm retained by the Employer and that the information requested was not maintained by the Employer as a separate data base. Further, CONSOL asserts

> that it relies upon eight separate law firms to provide expert witnesses and that it pays these law firms through itemized invoices, as opposed to directly paying the witnesses. Invoices prior to 2000 have been reduced to microfilm. Subsequent invoices are stored in separate locations. While invoices one to two years old would still be housed in CONSOL's accounting department, CONSOL states that they are "not particularly retrievable" as they are filed in chronological order. CONSOL only maintains a summary of the invoices and asserts that it would require additional staff to retrieve these invoices and set up a spreadsheet with the listed amounts. Further, CONSOL asserts that the financial information would be misleading because it may include the costs of medical testing as well as the costs relating to the physician. CONSOL did not address the issue of the burden that would be imposed upon the law firms in obtaining the information, although I requested at the hearing that it do so. (Tr. 79-80).
>
> In a letter response of April 18, 2006, Claimant noted that he was only seeking the requested information for Drs. Altmeyer, Meyer, and Fino (as the reports of the other physicians were not admitted), and had only requested records for the period from 2000 to 2005 (not the invoices on microfilm relating to the period prior to 2000). Claimant asserted that Employer had not shown that it would be unable to obtain the requested information from the law firms that act as its agents. Accordingly, Claimant asked that I compel Employer to answer Interrogatories 4 and 5 with respect to Drs. Robert B. Altmeyer, Christopher A. Meyer, and Gregory J. Fino.
>
> An Order of April 19, 2006 ordered the Employer to make reasonable efforts to respond to the two interrogatories relating to the three named physicians within thirty days.

Order on Reconsideration, June 27, 2006, 1-2.

In the April 19, 2006 Order, I had initially suggested two possible methods by which Employer could comply:

> First, as Claimant suggests, CONSOL could ask the law firms that it retains either to provide copies of itemized invoices submitted in the Black Lung claims for which they have been retained or, alternatively, provide the information requested with respect to the cases handled by that law firm. (That approach was suggested at the hearing. Tr. 18). Such requests would not have to cover the entire period from 2000 to 2005 if the information for the earlier portion of the period is not readily available. Those invoices or summaries could then be made available to Claimant for inspection and copying. Again, I am skeptical that the law firms would be unable to retrieve the requested information if they were to make a reasonable effort.
>
> Second, CONSOL could allow Claimant to inspect and copy invoices for the past one to two years that it maintains in its accounting department, as an

alternative to preparing a spreadsheet. Copies of such invoices could also be provided.

April 19, 2006 Order at 3. I also noted that there might be other reasonable approaches which could constitute a good faith effort to comply but that "Employer's attempt at stonewalling is simply insufficient." *Id.*

On May 23, 2006, Employer, through counsel's correspondence of May 19, 2006, moved for reconsideration of the April 19, 2006 Order. In its letter motion for reconsideration, Employer asserted that the methodology I suggested to lessen the burden was "still unduly burdensome, will not produce information which is relevant to resolve the issues presented, and causes disclosure of protected and confidential information that should be shielded from a fishing expedition." Letter motion for reconsideration (dated May 19, 2006) at p. 2. Employer again requested that it not be required to provide the information sought by the interrogatories. In a response filed on June 6, 2006, Claimant asked that the request for reconsideration be denied.

Since Employer argued it would have problems complying with either of my alternatives, I granted the motion for reconsideration, but on other grounds, and instead ordered it to provide the requested information in full. Order on Reconsideration, June 27, 2006 at 4-5. In so ruling, I noted that I was still not persuaded by the vague assertions of burdensomeness and privilege, and I continued to find that the information sought was relevant to the issues of potential bias and credibility.

On July 26, 2006, Employer filed an interlocutory appeal with the Benefits Review Board ("the Board") challenging my April 19, 2006, and June 27, 2006, orders. I consequently stayed the proceedings until the Board issued a decision. By way of unpublished decision issued September 29, 2006, the Board dismissed Employer's appeal because it did not satisfy the three-prong requirements for an interlocutory appeal. *[Claimant] v. Consolidation Coal Co.*, BRB No. 06-0812, at 2 (Sep. 29, 2006). Moreover, the Board noted that the Orders were in compliance with the Administrative Procedure Act. *Id.* Thereafter, I lifted the stay and ordered Employer to comply with Claimant's discovery requests. Order Lifting Stay and Scheduling Proceedings of December 18, 2006.

After Claimant received the requested information, and filed it with this tribunal on February 7, 2007 as Claimant's Exhibit 7, Employer filed a Motion to Strike the Exhibit. In addition to striking the exhibit, the Motion also asked that I provide Employer with a protective order were I to decide the information should not be stricken. Order Denying Employer's Motion to Strike and Protective Order of March 23, 2007 at 8 (citing Employer's Motion to Strike at 5). Employer argued that Claimant had not established a substantial need for the information, the information produced was irrelevant and that the information was privileged and should not be discoverable.

First, I rejected Employer's argument that Claimant had not shown a substantial need for the documents as this argument was centered around its erroneous interpretation of the Board's decision in *Keener v. Peerless Eagle Coal Co.*, BRB No. 05-1008 BLA, at 11-12 (Jan. 26, 2007).

Briefly stated, *Keener* involved a party seeking to obtain information used in anticipation of litigation (such as the opinions of consulting experts only). As this was not the type of information being sought in the instant case, I rejected this argument. March 23, 2007 Order at 5-6. Further, I noted that *Keener* was decided in the context of a discovery dispute, not with respect to information that had already been produced as a result of discovery. March 23, 2007 Order at 6.

Second, I rejected Employer's privilege argument because it had actually not raised the privilege prior to filing its Motion to Strike and, by providing documents instead of interrogatory responses, it waived any privilege with respect to these documents. March 23, 2007 Order at 6-7. Notably, it did not object to the interrogatory as seeking privileged information.[8]

Third, I disagreed that the information being sought was irrelevant. In doing so, I discussed Fourth Circuit authority which had clearly noted potential biases of an expert witness in black lung litigation, or any litigation, could properly be explored. March 23, 2007 Order at 7-8 (citations omitted).

Fourth, I rejected Employer's request for a protective order with respect to the information produced as a part of Claimant's Exhibit 7. Initially, I noted that 29 C.F.R. §18.15, which allows the issuance of protective orders, applies only in the discovery context. March 23, 2007 Order at 8. Next, I stated that even if the regulation was applicable, Employer had not met its burden in establishing that the production of the evidence would pose an "annoyance, embarrassment, oppression, or undue burden or expense."[9] March 23, 2007 Order at 8-9.

In view of the above rulings, the Order denied the motion to strike, admitted CX 7 into evidence, closed the record, and gave the parties 30 days to file any written briefs. March 23, 2007 Order at 9. However, Employer had filed its post-hearing brief with this tribunal on March 22, 2007; Claimant filed his post-hearing brief with this tribunal on March 23, 2007.

ISSUES/STIPULATIONS

On the CM-1025 form, the following issues were listed as contested by the Employer: whether the claim was timely, whether Claimant was a miner, whether Claimant had post-1969 miner employment, whether Claimant had 33 years of coal mine employment, whether Claimant had pneumoconiosis, whether his pneumoconiosis arose from coal mine employment, whether he was totally disabled, whether his disability arose from coal mine employment, whether Claimant had one dependent for purposes of augmentation, and other issues for appellate purposes. (DX 45). The district director also contested the dependency issue but none of the other issues. *Id*. At the hearing, Employer withdrew the miner and post-1969 employment issues. (Tr. 52). The other issues listed above remain contested, except for length of coal mine employment and dependency, on which the parties have reached stipulations.

---

[8] See Employer's Response to Interrogatory 5, quoted above.

[9] Employer's actions in providing the documents that it claimed were privileged in lieu of the interrogatory answers is difficult to understand. In this regard, Employer has failed to take into consideration that I revoked the Order that gave Employer that alternative and instead ordered it to respond to the Interrogatories in my June 27, 2006 Order on Reconsideration. However, as Claimant has not objected, this matter will not be pursued further.

Employer stipulated to 32 years of coal mine employment, and Claimant's counsel indicated that this stipulation was acceptable. *Id.* I will accept the stipulation as it is consistent with the evidence of record and I find that Claimant has 32 years of coal mine employment. After Claimant testified, Employer stipulated to one dependent for purposes of augmentation.[10] (Tr. 70-71). That stipulation is also accepted.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Employment History

At the time of the hearing, Claimant was 68 years old and was married.[11] (Tr. 57). He was on oxygen. (Tr. 66).

The only coal mine employer that Claimant worked for was Consolidation Coal Co. (DX 23; *see also* Tr. 57). He worked for Employer from November 13, 1967 to August 31, 2000. (DX 23).

Claimant's last, and only, job with Employer was that of a mechanic. (Tr. 58, DX 23). Among his duties, he was responsible for repairing equipment, welding, and other miscellaneous tasks. (Tr. 57-58). The equipment he repaired was involved in coal mining. (Tr. 58). Claimant testified that he did most of his repair work in the mechanic shop, which was 800 to 1000 feet from the preparation plant. (Tr. 59). During his last few years of employment, a large stockpile of coal was kept near the preparation plant, and Claimant would be required to work on the coal feeder that processed it. (Tr. 60). His job required him to lift pieces of equipment, ranging from 50 pounds to 95 pounds, on a regular basis. (Tr. 61-62). He also occasionally repaired equipment in the preparation plant. (Tr. 62).

While working for Employer, Claimant was routinely exposed to coal dust. (Tr. 63). Most of the dust drifted over from the preparation plant. *Id*. The equipment Claimant had to repair was often covered in coal dust, and he would often have to use an air hose to blow off the dust. (Tr. 63-64). Claimant testified that although most of the equipment was repaired outside of the mechanic shop, it was often difficult to avoid coal dust. (Tr. 64). After leaving work, he was often covered in dust, and would often have to cough it out. (Tr. 65).

Claimant testified that he quit his job (in August 2000) because he was having breathing problems that prevented him from performing manual labor. (Tr. 65-66).

In 2001, Claimant began seeing Dr. Attila Lenkey for his breathing problems. (Tr. 66). Dr. Lenkey prescribed several medications, including oxygen. *Id*. Claimant used the oxygen 24 hours a day, and, as noted above, was on it the day of the hearing. (Tr. 66, 71).

---

[10] Claimant also had three children, but none of them were under the age of 18 at the time Claimant's claim was filed. (See DX 23).

[11] Although the transcript reflects that the Claimant testified that he was 58 years old, that is a transcription error. My notes from the hearing indicate that he stated he was 68 years old, and his claim form indicates that he was born in 1937. (DX 2).

Claimant testified that he smoked half a pack of cigarettes a day from the age of 25 to 60 (i.e., 1962 to 1997). (Tr. 67). He also had a bout of pneumonia in 2001 or 2002. (Tr. 69).

Medical Evidence Summary

X-ray evidence

The record consists of nine chest x-ray interpretations (relating to four chest x-rays dated July 20, 2001, September 18, 2002, September 24, 2002, and April 17, 2003) that have been interpreted in accordance with the ILO system: four from Claimant, four from Employer, and one from the district director. A quality interpretation of the September 18, 2002 film was also performed.

July 20, 2001 X-ray. This film was taken as part of Claimant's West Virginia claim for benefits. (DX 22). Evidence from state workers' compensation claims is not automatically admissible, but may be if designated by a party. Claimant designated the interpretation of Dr. William Noble performed on July 20, 2001 as part of his initial evidence. Dr. Noble is a certified B-reader and is also board-certified in radiology. (DX 20).

With respect to Dr. Noble's interpretation of the July 20, 2001 x-ray, it is first important to note that although a written summary prepared by Dr. Noble is in the record, there is no ILO form of record. In his written summary, Dr. Noble wrote that he found s/t opacifications of 1/0 profusion in the lower lung zones bilaterally, with more in his left lung than right. (DX 22). Although there is no ILO form of record, Dr. Noble wrote that this finding was based on an ILO classification. *Id*. Dr. Noble also wrote that he did not find any pleural abnormalities. *Id*. He also found that there was elevation of the left hemidiaphragm. *Id*. He did not give the film a quality rating but noted that the lung fields were accentuated by poor depth of inspiration. *Id.*

Employer had the July 20, 2001 film interpreted by Dr. Cristopher A. Meyer on April 23, 2003 as rebuttal evidence. (EX 2). Dr. Meyer is board-certified in radiology and is also a certified B-reader. *Id*. He found no pleural or parenchymal abnormalities consistent with pneumoconiosis, although he did write on the ILO form that he saw bibasilar air space disease as well as "likely atelectasis or scarring not a manifestation of CWP [coal workers' pneumoconiosis]." *Id*. He gave the film a quality 3 rating because of low lung volumes. *Id*. In his written statement, Dr. Meyer noted the presence of a bibasilar air space opacity but no fine irregular or fine nodular shadows. *Id.* He also noted elevation of the left hemidiaphragm. *Id*.

September 18, 2002 X-ray. This film was taken as part of Claimant's DOL sponsored pulmonary examination. (DX 20). As part of the exam, on September 30, 2002, the film was interpreted by Dr. Noble who, as noted above, is a dually qualified reader. *Id*. On the ILO form, he found parenchymal abnormalities consistent with pneumoconiosis profusion 1/0, s/t opacities in Claimant's two lower lung zones only. *Id*. He did not find any pleural abnormalities consistent with pneumoconiosis. *Id*. He did find elevation of both hemidiaphragms and possible enlargement of the left lobe of the thyroid. *Id*. Dr. Noble attached a written report detailing his

findings, but it merely restated his findings listed on the ILO form. *Id*. He gave the film a quality 1 rating. *Id*.

The film was reread for quality purposes only by Dr. Carl Binns on December 2, 2002. (DX 21). Dr. Binns is a certified B-reader and board-certified radiologist. *Id*. He gave the film a quality 2 rating because of shallow inspiration. *Id*.

In rebuttal to Dr. Noble's interpretation, Claimant submitted the November 22, 2005 interpretation of Dr. Afzal Ahmed. (CX 1). Dr. Ahmed is a certified B-reader and is also board-certified in radiology. *Id*. He found parenchymal (but not pleural) abnormalities consistent with pneumoconiosis 1/1 profusion, p/q opacities in all six zones. *Id*. He assigned the film a quality 2 rating because of left scapula overlay. *Id*. In his written report, Dr. Ahmed wrote that he saw parenchymal densities measuring up to 3 mm scattered throughout both lungs. *Id*. He also noted "[p]oor respiratory effort showing crowding of markings in the lung fields and compressed lung parenchyma/atelectasis at left base." *Id.* He also found blunting of the left costophrenic angle. *Id*. Dr. Ahmed concluded that Claimant's film showed simple pneumoconiosis. *Id*.

In rebuttal to Dr. Noble's interpretation, Employer submitted the February 12, 2003 interpretation of Dr. Paul Wheeler. (DX 26). Dr. Wheeler is board-certified in radiology and is also a certified B-reader. *Id*. Dr. Wheeler did not find any pleural or parenchymal abnormalities consistent with pneumoconiosis. *Id*. Dr. Wheeler found moderate hyperinflation with crowded lower lung markings that he believed may have been caused by Claimant's obesity. *Id*. He assigned a quality 3 rating because of the aforementioned hyperinflation and scapulae. *Id*. Dr. Wheeler wrote that there was no coal workers' pneumoconiosis or silicosis. *Id*.

September 24, 2002 X-ray. This film was taken as part of Dr. Robert Altmeyer's examination of Claimant on September 24, 2002. (DX 24). The film was interpreted by Dr. Cristopher Meyer (who, as noted above, is a dually qualified reader) on April 20, 2003. (EX 2). Dr. Meyer did not find any pleural or parenchymal abnormalities consistent with pneumoconiosis. *Id*. He found bronchovascular crowding in both lung bases with a bibasilar air space opacity which he stated was "presumedly compressive atelectasis or scarring." *Id*. He did not find any fine irregular or nodular shadows, but he did note there was "suggestion of a nodule overlaying the right anterior second right rib measuring approximately 1 cm." *Id*. Additionally, he saw a second nodule measuring 7 mm overlaying Claimant's left anterior third rib. *Id*. Dr. Meyer stated there was no radiographic evidence of coal workers' pneumoconiosis but recommended comparison with old films or a chest CT scan. *Id*. He gave the film a quality 1 rating.

In rebuttal to Dr. Meyer's interpretation of the September 24, 2002 x-ray, Claimant submitted the November 28, 2005 interpretation by Dr. Ahmed (a dually qualified reader, as noted above). (CX 3). Dr. Ahmed found parenchymal (but not pleural) abnormalities consistent with pneumoconiosis 1/1 profusion, p/q opacities in all six zones. *Id*. Dr. Ahmed marked the "pi" box under other abnormalities, indicating that he found pleural thickening in the interlobar fissure of mediastinum. *Id*. In his written statement, Dr. Ahmed said he found minute soft rounded parenchymal densities measuring up to 3 mm throughout both of Claimant's lungs. *Id*. Dr. Ahmed did not see pleural thickening or calcification; however, he did see elevation of the

left diaphragm and atelectasis at the left base. *Id*. He also noted the presence of air fluid level under the left diaphragm. *Id*. He assigned the film a quality 1 rating. *Id*. Dr. Ahmed concluded that Claimant's film showed simple pneumoconiosis. *Id*.

April 17, 2003 X-ray interpretation. Employer offered the May 25, 2003 interpretation by Dr. Meyer of the April 17, 2003 film taken during Dr. Fino's examination as part of its case-in-chief. (EX 2). Once again, Dr. Meyer did not see any pleural or parenchymal abnormalities consistent with pneumoconiosis. *Id*. Dr. Meyer also once again saw bibasilar air space disease that he attributed to either scaring or atelectasis. *Id*. Dr. Meyer commented that this film showed very low lung volumes that were secondary to basilar fibrosis or infradiaphragmatic process (possibly due to ascites). *Id*. However, Dr. Meyer did not find that this was a manifestation of coal workers' pneumoconiosis; in fact, Dr. Meyer did not find that there was any radiographic evidence of coal workers' pneumoconiosis. *Id*. He did also note that there were bronchovascular markings at Claimant's lower lung bases and he noted the presence of atherosclerotic calcification in the blood vessels. *Id*. He gave the film a quality rating of 2 due to quantum mottle. *Id*.

In rebuttal, Claimant offered the November 28, 2005 interpretation by Dr. Ahmed. (CX 2). Again, he found parenchymal (but not pleural) abnormalities consistent with pneumoconiosis 1/1 profusion, p/q opacities in all six zones. *Id*. He again found pleural thickening in the interlobar fissure of mediastinum. *Id*. In his written report relating to the April 17, 2003 x-ray, Dr. Ahmed again noted the presence of minute soft rounded parenchymal densities measuring 3 mm scattered throughout both lungs. *Id*. Dr. Ahmed also found compressed lung parenchyma and atelectasis at the lung bases as well as blunting of left costophrenic angle. *Id*. Dr. Ahmed found that this film showed simple pneumoconiosis. *Id*. He recommended that Claimant's personal physician be informed due to a question of minimal left pleural effusion. *Id.* He gave the film a quality 1 rating despite noting poor inspiratory effort in his statement. *Id*.

Pulmonary Function Tests

Four pulmonary function tests (including pre and post bronchodilator values) were submitted by the parties as affirmative evidence:

Exhibit No.	**Date/ Physician**	**Age/Height**	**FEV1**	**FVC**	**MVV**	**FEV1/FVC**
DX 22	07/20/01 Lenkey	63 67 inches	.97(pre) .85(post)	1.65(pre) 1.38(post)	27(pre)	59%(pre) 62%(post)
DX 22	04/23/02 Young	64 66.5 inches	1.49(pre) 1.68(post)	2.16(pre) 2.31(post)	49(pre) 50(post)	69%(pre) 72%(post)
DX 17	09/18/02 Saludes	65 68 inches	1.01(pre)	1.70(pre)	34(pre)	60%(pre)
DX 24	09/24/02 Altmeyer	65 67.5 inches	1.14(pre) 1.18(post)	1.98(pre) 1.93(post)	41(pre) 59(post)	57%(pre) 61%(post)
EX 3	04/17/03 Fino	65 66 inches	1.25(pre) 1.20(post)	1.94(pre) 1.75(post)	N/A	64(pre) 68(post)

In addition, the following pulmonary function test results were derived from Claimant's medical records and submitted post-hearing (as an exhibit to Dr. Lenkey's second deposition); however, there is only one tracing present and the test does not satisfy the quality standards in the regulations; moreover, the sex was listed as "F" suggesting that, if the typo were not discovered, the predicted values may have been incorrect.

Exhibit No.	Date/ Physician	Age/Height	FEV1	FVC	MVV	FEV1/FVC
EX 10, Exh. 3	02/23/05 Lenkey	67 68 inches	1.47(pre)	1.77(pre)	N/A	83%(pre) [calculated]

The printed interpretation for the February 23, 2005 test listed "Moderate Severe Restriction." (EX 10, Exh. 3). However, as this test does not meet the quality standards, it does not constitute evidence of the presence or absence of a respiratory or pulmonary impairment under 20 C.F.R. 718.103(c). An additional test taken in November 2005, that may have met the quality standards, was referenced in Dr. Lenkey's second deposition but will not be considered as the test results are not of record (except as summarized in the testimony). (EX 10 at 28-30). While that test would be admissible as a medical record, Dr. Lenkey's discussion of it is not the best evidence of the test results; further, it cannot be determined whether the quality standards were, in fact, satisfied without obtaining the tracings and printed report.

Under subparagraph (i) of section 20 C.F.R. 718.204(b)(2), total disability is established if the FEV1 is equal to less to or less than the values set forth in the pertinent tables in 20 C.F.R. Part 718, Appendix B, for the miner's age, sex and height, if in addition, the tests reveal qualifying FVC or MVV values under the tables, or a FEV1/FVC ratio of less than 55%. All of the tests produced qualifying values based upon the FEV1 and either the MVV or FVC, or both.

Arterial Blood Gases

Four arterial blood gas (ABG) studies (taken at rest) were submitted as affirmative evidence:

Exhibit No.	Date	Physician	PCO2	PO2	Qualifying?
DX 22	07/20/01	Lenkey	45.3(R)	58.8(R)	Yes
DX 17	09/17/02	Saludes	45.8(R)	57.2(R)	Yes
DX 24	09/24/02	Altmeyer	43.7(R)	54.6(R)	Yes
EX 3	04/17/03	Fino	44(R)	59(R)	Yes

Total disability may be established through arterial blood gas studies if they produce qualifying values under Part 718, Appendix C. 20 C.F.R. §718.204(b)(2)(ii). All of the above values were qualifying. In this regard, for a PCO2 value from 40 to 49, a PO2 value equal to or less than 60 is qualifying for altitudes up to 2999 feet.

Medical Opinions

Claimant submitted two medical opinions; Employer submitted two opinions; and one opinion was submitted by the district director as part of the DOL sponsored exam. In addition to reports from each physician, the transcripts of several depositions were submitted.

Dr. Attila Lenkey. Two separate written opinions (one of July 20, 2001, and the second of December 19, 2005) were submitted by Dr. Attila Lenkey, Claimant's treating physician. (DX 22, CX 5). Additionally, Dr. Lenkey also gave two separate depositions (on December 16, 2002 and May 15, 2006). (DX 25, EX 10). Dr. Lenkey's practice is primarily devoted to pulmonary medicine, and he is board-certified in internal medicine, pulmonary medicine, and sleep disorders medicine. (DX 25 at 7-8; EX 10 Exh. 1 [curriculum vitae]). He is not a certified B-reader. *Id.*

(1) Dr. Lenkey first examined Claimant on July 20, 2001 and prepared a report detailing his findings.[12] (DX 22). At that time, Claimant was 63 years old, and he complained of chronic breathlessness, exertional dyspnea, chronic cough with phlegm production, chronic wheezing, and nocturnal dyspnea. *Id*. Dr. Lenkey reported a "noncontributory" family history. *Id*. Claimant told Dr. Lenkey that he had worked in coal mines from November 1967 to August 2000 as a general laborer and mechanic, with most of his work performed underground and that he smoked half a pack of cigarettes from age 25 to 59; Dr. Lenkey gave Claimant a 40 pack year history. *Id*. On physical examination, Dr. Lenkey noted diminished breathing sounds with end expiratory wheezing and occasional rhonchi that did not clear with cough. (DX 22). Pulmonary function and arterial blood tests conducted during this examination are summarized above. Dr. Lenkey relied upon a chest x-ray interpretation by Dr. Noble (discussed above) (DX 22); however, he also reviewed the x-ray himself. (DX 25 at 16-19).

Based upon the July 20, 2001 examination, Dr. Lenkey listed the following under "Conclusion:"

1. Coal Workers Pneumoconiosis 50% impairment
2. Chronic bronchitis
3. Tobacco exposure 50% impairment

(DX 22). Dr. Lenkey determined that Claimant had marked pulmonary physiologic impairment with marked air flow limitation and hypercarbia with significant deoxygenation. *Id*. He stated that Claimant "in all likelihood has chronic [sic] pulmonale from his underlying pulmonary disease," although he did not explain the basis for this conclusion. *Id*. He determined that Claimant's impairment was 50% the result of coal workers' pneumoconiosis, and 50% the result of cigarette smoke. *Id*. In explanation, he stated that Claimant smoked for "a fair period of time" and "it is well known that tobacco and coal dust work in an additive fashion."[13] *Id*.

[12] Dr. Lenkey's first opinion was proffered as part of Claimant's state compensation claim, and was designated by Claimant as part of his case-in-chief. (DX 22).

[13] At his second deposition, Dr. Leakey mentioned the studies upon which he relied. (EX 10 at 26-27).

On January 7, 2003, Dr. Lenkey gave a deposition concerning the above report and elaborated upon his opinion. (DX 25). Dr. Lenkey testified that his first contact with Claimant was at the time of the July 20, 2001 examination and he saw Claimant nine times between August 31, 2001 and December 3, 2002. (DX 25 at 9, 12). He stated that Claimant had sufficient years of coal dust exposure to make him susceptible to coal workers' pneumoconiosis. (DX 25 at 15). He had seen Claimant once in the past for possible asbestos exposure in connection with a class action but did not indicate the source of Claimant's exposure.[14] (DX 25 at 15-16). Although he noted that the irregular (s/t) opacities found were more typical of asbestosis than coal workers' pneumoconiosis, he explained that there can be a "mixing and matching" of opacities. (DX 25 at 17-18). Discussing the pulmonary function test values he obtained, Dr. Lenkey indicated that Claimant had severe obstructive airway impairment with no improvement post-bronchodilator. *Id*. He also stated that the arterial blood gas study results he obtained were abnormal, in that his increase in carbon dioxide indicated airflow obstruction while his low oxygen level showed trouble with oxygenation. *Id*. Although he did not obtain post-exercise arterial blood gas values, a cardiopulmonary stress test was performed on Claimant which revealed that his work capacity was diminished indirectly, his heart could not totally compensate for his pulmonary problems, and he was on a borderline of needing to wear oxygen with exercise. (DX 25 at 28). Dr. Lenkey opined Claimant was 20 to 30 pounds overweight and, while it could affect his ability to breathe and get around, it was not severe enough to affect his pulmonary function test results. (DX 25 at 30). Likewise, he did not believe that someone with Claimant's smoking history would have the degree of impairment Claimant had. (DX 25 at 31). Dr. Lenkey also noted that he believed Claimant had been placed on oxygen in September 2001, and had been on and off it since. (DX 25 at 33-34).

Dr. Lenkey opined Claimant could not return to his previous job, and although he admitted that he did not know details about the amount of physical labor involved with his last job, he did not believe Claimant could keep up and perform any work that required more than "a bare minimum of exertion." (DX 25 at 34-35).

(2) Dr. Lenkey offered a second opinion dated December 19, 2005. (CX 5). He also gave a deposition concerning this opinion on May 15, 2006. (EX 10). Dr. Lenkey was now board-certified in pulmonary medicine, in addition to his other credentials mentioned *supra*. (EX 10 at 7). As noted above, Dr. Lenkey discussed treatment records relating to Claimant in his report and, as provided at the hearing, copies of some treatment records were attached to his deposition transcript. The attachments to Dr. Lenkey's deposition include his curriculum vitae (Exhibit 1); his December 19, 2005 report (Exhibit 2); a pulmonary function test taken on February 23, 2005[15] (Exhibit 3); an interpretation by hospital radiologist Dr. Mark Kenamond of a July 11, 2005 chest x-ray (Exhibit 4); an interpretation of a CT scan taken on February 2, 2005 by Dr. Kelby Frame (Exhibit 5); and an interpretation of a CT scan , taken on June 7, 2004, also

[14] Lung disease caused by asbestos exposure (e.g., asbestosis) would be compensable as legal pneumoconiosis if caused by exposure to dust containing asbestos during coal mine employment. However, no physician has diagnosed asbestosis or other asbestos-related disease.

[15] Although in his December 19, 2005 report, Dr. Lenkey mentioned pulmonary function testing conducted on "11/18/05" at Ohio Valley Medical Center (CX 5; EX 10 Exh. 2) and relied upon that test in formulating his opinion (EX 10 at 28 to 30), the results of that test were not attached. Instead, only the nonconforming PFT from "02/23/05" (also referenced in the report and deposition) was attached to the deposition. (EX 10, 19-20, Exh. 3).

by Dr. Kelby Frame (Exhibit 6). The results of referenced November 18, 2005 PFTs and undated arterial blood gases (which may be of record in DX 22) were not included.

In the December 19, 2005 report, Dr. Lenkey noted that he had been treating Claimant for approximately five years for his occupational lung disease and chronic bronchitis. (CX 5; EX 10 Exh. 2). Dr. Lenkey noted that Claimant still complained of significant pulmonary symptoms, and they were the same as he summarized in his previous report. *Id.* At the time of the examination, Claimant was 67 years old, was 67 inches tall, and weighed 202 pounds. *Id.* At that time, he was on 2½ liters of oxygen a day, Spiriva (a bronchodilator), and Albuterol nebulizer treatments. *Id.; see also* EX 10 at p. 12. Dr. Lenkey reiterated his conclusions that the Claimant was unable to do his last underground coal mining job based on his present pulmonary disease and that 50% of his disability was due to his significant coal dust exposure while the other 50% was due to his smoking history. *Id.*

At his May 15, 2006 deposition, Dr. Lenkey discussed his treatment of the Claimant and elaborated upon the medical records attached to his deposition. He estimated that in the span of five years, he had seen Claimant 15 to 20 times. (EX 10 at 12, 33). Dr. Lenkey explained the basis for his opinion in some detail, noting that his conclusions were based upon the x-rays, CT scans, pulmonary function testing, arterial blood gases, and physical findings, coupled with the Claimant's occupational history. (EX 10 at 17-18, 34-46). However, Dr. Lenkey apparently relied upon a "full PFT dated November '05" (done at Ohio Valley Medical Center) that is not of record (and is apparently inconsistent with the nonconforming PFT of February 2005 attached to his deposition as Exhibit 3). (EX 10 at 28-30, Exh. 3).

Based upon the pulmonary function testing, Dr. Lenkey explained that Claimant suffered from a mixed defect, including mild obstruction and mild to moderate restriction. (EX 10 at 29). Dr. Lenkey explained that he attributed 50% of the disability to coal dust exposure, and 50% to cigarette smoke based upon the almost four decades of coal mine dust exposure and essentially the same number of cigarette pack years. (EX 10 at 26). He stated that Claimant was only mildly obese but indicated that up to 10 to 12% of the restrictive component could be attributed to obesity. (EX 10 at 19, 27). Likewise, he characterized the Claimant's smoking history as moderate. (EX 10 at 14-15).

Dr. Lenkey opined that his diagnosis of coal workers' pneumoconiosis was strongly supported by the radiographic evidence (both x-ray and CT scan) and Claimant's history of coal dust exposure. (EX 10 at 17-18). Focusing on the July 11, 2005 interpretation, Dr. Lenkey noted that Dr. Kenamond saw changes that indicated a possible fibrotic process, which according to Dr. Lenkey, could indicate coal dust exposure. (EX 10 at 39-40). However, he admitted that fibrosis could have causes besides coal dust. (EX 10 at 52). Although the 2004 scan said a collapsed lung and changes due to atelectasis were present, Dr. Lenkey did not believe either would create interstitial changes. (EX 10 at 17-18). According to Dr. Lenkey, the 2005 CT scan showed nodular fibrotic changes that were consistent with coal dust exposure. (EX 10 at 42-43). It also showed loss of left lung volume and mild emphysema. (EX 10 at 43).

Dr. Melvin Saludes. Claimant was examined by Dr. Melvin Saludes on November 6, 2002 as part of the DOL's initial examination. (DX 13). Additionally, Employer took a single

deposition of him on March 24, 2003. (DX 27). Dr. Saludes is board-certified in internal and pulmonary medicine, and focuses his practice primarily in pulmonary medicine. (DX 27 at 6). He is not a certified B-reader. (DX 27 at 7).

As part of the Department of Labor examination, Dr. Saludes took a complete history (employment, family, medical, and social/smoking); recorded complaints and physical examination findings; listed cardiopulmonary diagnoses and their etiology; and stated degree of impairment and the extent attributable to the cardiopulmonary diagnoses. (DX 13). As part of his pulmonary examination of Claimant, Dr. Saludes obtained results of a resting arterial blood gas study, pulmonary function test, and electrocardiogram, as well as an interpretation of the chest x-ray taken as part of the exam. *Id.*. Dr. Saludes' written report noted that he relied upon the Claimant's July 2, 2002 employment history, Form CM-911a (DX 4).[16] (DX 13). Claimant told Dr. Saludes that he had pneumonia once, wheezing for the past three years, and high blood pressure since the age of 62. (DX 13). He also noted that Claimant's mother had been diagnosed with chronic obstructive pulmonary disease ("COPD").[17] *Id.* Dr. Saludes recorded a smoking history of one half pack per day from age 25 to age 55. *Id.* At the time of the examination, Claimant was 5'8", and weighed 208 pounds.[18] *Id.*

Dr. Saludes reached the following cardiopulmonary diagnoses: (1) COPD based upon PFTs showing severe obstruction and restriction; (2) Obesity; and (3) Coal Workers' Pneumoconiosis. He listed history of cigarette smoking and history of coal dust exposure of 33 years as the etiology of the diagnoses, and in a note apparently added later (in blue ink) he indicated that both of the above were known causes of obstructive lung disease. (DX 13). With respect to impairment, he opined that the Claimant was totally disabled ("100% impairment") based upon an FVC of 42% of predicted and a PO2 of 57 on room air. *Id.* He attributed 75% of the impairment as secondary to underlying COPD/obesity and 25% to coal dust exposure. *Id.*

At his March 24, 2003 deposition, Dr. Saludes explained the basis for his opinion in more detail. (DX 27). He indicated that did not review any medical records, aside those produced from his own examination, and admitted it would be helpful to do so in order to diagnose any conditions Claimant was suffering from. (DX 27 at 11). He indicated that the Claimant had mentioned possible asbestos exposure when he worked at a toy plant, but that Claimant did not discuss that in detail. (DX 27 at 14). Dr. Saludes apparently reviewed the x-ray himself but did not interpret it, relying instead upon Dr. Noble's interpretation. (DX 27 at 21). He stated that, in his experience, simple pneumoconiosis resulted in very minimal impairment. (DX 27 at 9). Dr. Saludes explained that he would need a positive x-ray to make a diagnosis of clinical pneumoconiosis but that the x-ray findings did not necessarily correlate with the degree of impairment. *Id.* Dr. Saludes also determined that Claimant was suffering from both coal workers pneumoconiosis resulting from coal dust exposure and COPD, which was the combined result of coal dust exposure, his cigarette smoking habit, and genetic predisposition, i.e., his

[16] On page 1, Box B, Dr. Saludes indicated that this history was attached but it was not. (DX 13) At his deposition, Dr. Saludes testified that he was aware that Claimant had coal mine employment from 1967 through 2000, and that most of it was underground. (DX 27 at 13-14). He also believed that Claimant's work involved moderate labor. (DX 27 at 29).

[17] At his deposition, Dr. Saludes suggested that Claimant's mother's history of COPD could make Claimant more susceptible to the disease from a hereditary standpoint. (DX 27 at 15-16).

[18] At his deposition, Dr. Saludes stated this showed Claimant was only mildly obese. (DX 27 at 18).

mother's history of COPD. (DX 27 at 28-30). However, Dr. Saludes could not actually determine how much smoking or coal dust actually contributed to Claimant's COPD. *Id*.

Dr. Saludes also discussed the results of the pulmonary function test and arterial blood gas study he obtained (summarized above). Analyzing the PFT results, Dr. Saludes concluded that they showed both an obstructive and restrictive pattern, i.e., the reduction in FVC value showed a restriction, while the FEV1 value showed an obstruction. (DX 27 at 24, 26). Dr. Saludes interpreted the ABGs as showing significant hypoxia, which could possibly indicate a coal dust related disease. (DX 27 at 27). He concluded that Claimant was impaired because of his underlying COPD that was caused by cigarette smoke and coal dust exposure and he classified the degree of impairment as severe. (DX 27 at 30). While he opined that Claimant's impairment was 25% the result of coal dust exposure, he admitted this was an essentially educated guess. (DX 27 at 31).

As Dr. Saludes did not have a second deposition taken, he was not given the opportunity to discuss the 2005 x-rays and test results.

Robert Altmeyer. Claimant was examined by Dr. Robert Altmeyer on behalf of the Employer on October 3, 2002. (DX 24). Two depositions were taken of Dr. Altmeyer, one on January 14, 2002 and the other on April 21, 2006. (EX 1, EX 9). Dr. Altmeyer is board-certified in internal medicine with subspecialties in pulmonary diseases and geriatric medicine, and he is also certified as a B-reader (EX 1 at 6).

Dr. Altmeyer's report included an occupational and medical history, cardiopulmonary complaints, physical examination findings, and test results. (DX 24). By way of history, he learned that Claimant had worked for Employer from 1967 until 2000. *Id.* He also learned that Claimant spent most of his employment as a mechanic fixing various pieces of equipment, which often required him to lift 50 to 100 pounds on a regular basis. (DX 24). He also worked as a beltman and often shoveled coal. *Id*. Dr. Altmeyer also noted that as a mechanic, Claimant apparently installed and removed asbestos and also worked with asbestos arc shoots. *Id*. According to Dr. Altmeyer, Claimant denied any dust exposure in his previous non-coal-mine employment, including his work for a toy factory. *Id.* Claimant also told Dr. Altmeyer he smoked one half to one pack of cigarettes a day from the age of 25 to 59 and he advised that his mother had bronchial problems. *Id.* In connection with this examination, Dr. Altmeyer examined Claimant and obtained the results of a pulmonary function test and an arterial blood gas study, the results of which are summarized above. *Id.* Dr. Altmeyer listed a height of 67.5 inches and weight of 208 pounds. *Id.* Dr. Altmeyer also had an x-ray taken and apparently interpreted the film himself, although his interpretation was not designated by Employer and (while stated in the deposition transcript) is not otherwise of record. (EX 1 at 31-32)

Dr. Altmeyer also listed documents that he reviewed and responded to specific questions posed by the Employer. Dr. Altmeyer concluded that Claimant was not suffering from coal workers' pneumoconiosis or silicosis. (DX 24). He reached this conclusion based primarily upon the results of the radiographic evidence available to him at the time, and specifically the absence of small rounded opacities in the upper lung zones, as well as the Claimant's symptomatology and the pattern of impairment reflected on physiologic testing. *Id.*

At his first deposition, Dr. Altmeyer elaborated upon the basis for his opinions. He testified about his interpretation of the x-ray taken at the time of his examination; additionally, he testified that he reviewed the films taken on July 20, 2001 and April 17, 2003. (EX 1 at 31-35). It was Dr. Altmeyer's opinions that these films all showed s/t, irregular shaped opacities in Claimant's lower lung zones. (EX 1 at 32-34). He stated this was rare in coal workers' pneumoconiosis, because he would expect to see regular shaped opacities in the upper lung zones that could potentially progress to the lower lung zones. (EX 1 at 32-33). With respect to the pulmonary function tests, Dr. Altmeyer agreed Claimant had a mild to moderate airway obstruction as well as a ventilatory restriction. (EX 1 at 15-16). He attributed Claimant's ventilatory restriction entirely to Claimant's obesity. (EX 1 at 16, 26). He explained that complicated coal workers' pneumoconiosis causes restrictive and obstructive impairments, but simple coal workers' pneumoconiosis created obstructive impairments only. (EX 1 at 9). Dr. Altmeyer paid special attention to Claimant's pot belly, because excessive fat in the abdominal region could impair breathing ability in that it presses up against a patient's diaphragm and reduces the lung capacity. (EX 1 at 25). He opined that Claimant's arterial blood gas study was affected by his obesity as well because his elevated diaphragm caused a mismatching of ventilation of air and perfusion of blood to the bottom of his lungs, which were being compressed. (EX 1 at 27). This, in turn, led to a drop in the arterial oxygen level. *Id*.

Dr. Altmeyer testified at a second deposition on April 21, 2006. (EX 9). This deposition occurred after he had reviewed the documents submitted as part of Dr. Lenkey's second deposition. After reviewing the radiographic evidence, Dr. Altmeyer again concluded that it did not show evidence of coal workers' pneumoconiosis. (EX 9 at 17). With respect to the July 11, 2005 x-ray interpretation by Dr. Mark Kenamond, which did not use the ILO classification system, Dr. Altmeyer still believed his interpretation was useful. (EX 9 at 8-10). Because Dr. Kenamond did not describe finding coal workers' pneumoconiosis, Dr. Altmeyer felt that the interpretation supported his conclusion that Claimant did not have the disease. (EX 9 at 10). Dr. Altmeyer also indicated that CT scans could be used to determine whether or not someone was suffering from coal workers' pneumoconiosis and opined that the two CT scan interpretations he reviewed did not support a diagnosis of coal workers' pneumoconiosis. (EX 9 at 13). In this regard, he noted that the 2004 CT scan described low lung volume at the left base and elevation of the left hemi-diaphragm. (EX 9 at 13-14). Dr. Altmeyer stated that the 2005 CT scan reading was essentially the same, although there were now mild interstitial nodular changes suspected peripherally, more in the upper and mid left lungs than right. (EX 9 at 14). His conclusion that the CT scans did not support a diagnosis of coal workers' pneumoconiosis had three bases: (1) the changes were more in the left zones than the right; (2) the changes were primarily in the middle zones rather than the upper zones; and (3) the 2005 scan was the first time changes were seen, which would be unusual since his last coal dust exposure was around five years prior. (EX 9 at 16). Further, he stated that these nodules could be indicative of an acute disease process, as many diseases could create these types of nodules; however, he did not hazard a guess as to the actual cause. (EX 9 at 16-17). Dr. Altmeyer reiterated that the 2005 CT scans did not expressly mention coal workers' pneumoconiosis, only that it was merely "suspicious" of nodular changes. (EX 9 at 27-28).

After reviewing the February 2005 (nonconforming) PFT, Dr. Altmeyer concluded that Claimant no longer had an obstruction, although there was still a restriction present. (EX 9 at 18, 20-21). He first noted that there had been an improvement in the pre-bronchodilator FEV1 values from his 2002 PFT of Claimant. (EX 9 at 18). Although the 2005 FEV1 was 57% of predicted, and the FVC was 58% of predicted, the FEV1/FVC ratio was normal; this indicated to Dr. Altmeyer that there was no longer an obstruction.[19] (EX 9 at 19). He opined that the reduced FVC and FEV1, coupled with lack of radiographic evidence of coal workers' pneumoconiosis, showed that Claimant had a restriction that was the result of his obesity. (EX 9 at 21; *see also* EX 9 at 25). However, he admitted that coal dust can create a restriction. (EX 9 at 26). He noted that the ventilatory studies were consistent with Claimant's breathing problems. (EX 9 at 20-21). He also noted that cigarette smoking can cause an obstruction that continues after smoking has ceased. (EX 9 at 24).

Dr. Gregory Fino. Dr. Gregory Fino examined Claimant on April 17, 2003, and provided a report of his findings dated April 29, 2003. (EX 3). He also testified by deposition twice: first on January 3, 2005 (EX 8), and again on June 5, 2006 (EX 11). Dr. Fino is board-certified in internal medicine with a subspecialty in pulmonary disease. (EX 4). He is also a certified B-reader under NIOSH standards. *Id.*

As did the other physicians, Dr. Fino took a complete history. (EX 3). Claimant reported 33 years of coal mine employment that ended in 2000, with three years underground, and the remainder above ground; his last job was as a mechanic. (EX 3). Claimant reported that he had breathing problems for the past six years, a daily cough with mucous production, wheezing, and dyspnea after walking on level ground, walking up hills, climbing stairs, or performing any type of manual labor. *Id.* Dr. Fino reported that there was no family history of lung disease or history of rib fracture, contrary to the history Claimant provided to Dr. Altmeyer. *Id.* Dr. Fino also reported that Claimant had an episode of pneumonia in 2002, that he had high blood pressure and cholesterol in 2001, and that he had non-insulin dependent diabetes beginning in 2003. *Id.* Dr. Fino reported that Claimant was on the following breathing medications: ipratropium bromide, Albuterol sulfate, and Advair. *Id.* Additionally, he was also on oxygen (1½ liters a day, and 2 a night), and had been so for two years. *Id.* He did not take any breathing medications the morning of his examination. *Id.* Claimant stated that he smoked half a pack of cigarettes a day from 1957 until 1993 (36 years). *Id.* At the time of this examination, Claimant was 66 inches tall, and weighed 202 pounds. *Id.*

Dr. Fino performed a physical examination and obtained the results of a chest x-ray, a pulmonary function test, and an arterial blood gas study. (EX 3). Dr. Fino also reviewed other documents which are of record. *Id.* Based upon a review of all of the above, Dr. Fino diagnosed (1) obstructive lung disease, chronic obstructive bronchitis and emphysema due to smoking; and (2) restrictive lung disease due to a non-occupational pulmonary fibrotic process and obesity. (EX 3). Although he opined that the Claimant was totally disabled from a respiratory standpoint, and was unable to return to his last coal mine job or a job requiring similar effort, he did not

[19] Dr. Lenkey stated in his report that the FEV1/FVC was 57% of predicted, but that statement is contrary to the exhibit which does not include a reported FEV1/FVC value, and a calculated value would be close to expected. (CX 5; EX 10. Exh. 3). At the time of the February 2005 PFT, the FEV1 value was 57% of expected and the FVC value was 58% of expected, but, as noted above, the expected values may not be correct.

attribute any significant impairment or disability to either his smoking or his working in the mines. *Id.* Rather, he opined that the primary disability was a restrictive one, which could be caused by fibrosis; however, Dr. Fino stated that the predominance of irregular opacities in the lower lung zones which he found on the x-rays was not consistent with coal dust, silica, or other coal mine dust.[20] *Id.*

Turning to Dr. Fino's first (January 3, 2005) deposition, Dr. Fino testified that he did not find medical (clinical) pneumoconiosis. (EX 8 at 16). Dr. Fino reviewed Dr. Meyer's interpretation of the film taken during his April 17, 2003 examination and Dr. Noble's interpretation of the September 18, 2002 film. (EX 8 at 11, 14). However, he also testified that he reviewed interpretations by Drs. Lenkey and Altmeyer, (EX 8 at 12). Dr. Fino testified that these interpretations showed irregular opacities in the lower zones, which was consistent with what he believed was present. (EX 8 at 14). He also disagreed with Dr. Lenkey's contention that coal workers' pneumoconiosis could be diagnosed if opacities were seen in the lower lung zones, although he stated there were many other pneumoconioses that could give rise to opacities in the lower lung zones. (EX 8 at 13-14). Dr. Fino opined that pulmonary fibrosis was largely responsible for Claimant's shortness of breath, i.e., his restriction. (EX 8 at 10, 15). Dr. Fino diagnosed Claimant with idiopathic pulmonary fibrosis. (EX 8 at 18-19). Based upon his interpretation of the film, Dr. Fino did not believe Claimant's pulmonary fibrosis was caused by coal dust exposure. (EX 8 at 20).

It was Dr. Fino's opinion that Claimant did not have legal pneumoconiosis either. (EX 8 at 16). Dr. Fino indicated that the pulmonary function tests showed obstruction and restriction, but there was significantly more restriction, which indicated the possibility of pulmonary fibrosis. *Id*. He did not believe that obesity was the sole cause of Claimant's restriction, but he agreed it was possible it could be the sole cause. (EX 8 at 20-21). With respect to Claimant's obstruction, reflected by Claimant's reduced FEV1/FVC ratio, Dr. Fino diagnosed chronic obstructive bronchitis resulting from cigarette smoking but did not believe it caused or contributed to Claimant's disability. (EX 8 at 10-11, 16). Dr. Fino felt this would be the case even if the obstruction were entirely the result of coal dust exposure (although he felt the obstruction was entirely the result of cigarette smoking). (EX 8 at 10-11). Dr. Fino associated the chronic obstructive bronchitis with cigarette smoke, and not coal dust exposure, because it continued even after Claimant had ceased coal mine employment. (EX 8 at 16-17). Further, Dr. Fino noted that the obstruction, along with Claimant's reduced diffusing capacity, suggested the presence of emphysema but could also be the result of Claimant's pulmonary fibrosis. (EX 8 at 17-18). Dr. Fino did not find support for a diagnosis of asthma. (EX 8 at 18).

Dr. Fino concluded his first deposition by stating his opinion that Claimant's respiratory impairment was not caused or aggravated by coal dust exposure, and he opined that Claimant would be just as disabled had he not been exposed to coal dust. (EX 8 at 22-23). Dr. Fino also stated that years of coal dust exposure alone was not indicative of whether one would get a disabling coal dust related condition. (EX 8 at 21-22).

[20] Dr. Fino's interpretation has not been designated by Employer and is not of record. As noted above, Dr. Lenkey stated that irregular opacities were consistent with asbestosis.

Dr. Fino gave a second deposition on June 5, 2006. (EX 11). In this deposition, Dr. Fino reviewed the documents that were submitted as part of Dr. Lenkey's deposition taken on May 15, 2006. Dr. Fino once again concluded that Claimant was not suffering from coal workers' pneumoconiosis and also lacked the respiratory capacity to return to his previous coal mining duties; however, Dr. Fino did change his assessment with respect to the cause of Claimant's disability.

Initially, Dr. Fino discussed the new radiological evidence. Examining an interpretation of a x-ray taken on July 11, 2005, and interpreted by Dr. Mark Kenamond, Dr. Fino commented that the interpretation stated there were likely fibrotic mild increased markings in Claimant's left lung base. (EX 11 at 6-7). Dr. Fino stated this supported his finding that there was not radiographic evidence of coal workers' pneumoconiosis, as any associated changes would begin in the upper regions, not the lower regions. (EX 11 at 7). Additionally, Dr. Fino discussed the CT scan interpretations of February 2, 2005 and June 7, 2004. He stated that CT scan interpretations are better than x-rays at discovering the source of a patient's lung problems. (EX 11 at 9). He noted that the only abnormalities mentioned by the 2004 CT scan were the elevation of the left diaphragm and associated loss of volume in the left lung. *Id*. Dr. Fino noted that the 2005 scan showed loss of lung volume, and mild interstitial nodular changes, more in the mid and perhaps upper lung fields on the left side, which could indicate some possible exposural disease, according to the radiologist. (EX 11 at 9-10). However, he stated that these subtle changes were insufficient to cause the restrictive defect that Claimant has; moreover, he stated that the CT scans showed "essentially no fibrosis" and ruled out pulmonary fibrosis and simple coal workers' pneumoconiosis. (EX 11 at 11-12). Dr. Fino suggested that the loss of lung volume in the left lung demonstrated on the CT scans could partially account for Claimant's restriction. (EX 11 at 12).

In addition to the newly submitted radiographic evidence, Dr. Fino also relied on the newly submitted February 23, 2005 (nonconforming) pulmonary function test to conclude Claimant did not have pulmonary fibrosis. (EX 11 at 14). While he indicated that this PFT was "in the same ballpark" as his own PFT, he interpreted it as showing "a pure restrictive defect without any evidence of obstruction," meaning that the obstruction he found had "gone away." (EX 11 at 13). This indicated to Dr. Fino that the obstruction seen in his exam was not coal dust related, as it would not dissipate with time if it were. *Id*. However, he still believed the restriction was present, and he now attributed it entirely to obesity. (EX 11 at 14). He said obesity was the cause because of Claimant's body mass index, lung volume loss, reduced FVC and FEV1, and lack of radiographic evidence of pulmonary fibrosis on the CT scans that could account for the reduced lung function (50% from normal). (EX 11 at 14-15).

Dr. Fino disagreed with Dr. Lenkey's conclusion that Claimant was suffering from a pulmonary impairment that was 50% attributable to coal dust exposure, and 50% attributable to cigarette smoke. (EX 11 at 16). Since Dr. Fino did not see any obstruction, he did not believe smoking would have any effect on Claimant's impairment. (EX 11 at 17). He also believed that the CT scans did not show a fibrotic process caused by coal dust, which in turn could have impacted Claimant's breathing. *Id*.

Treatment Records/CT Scan Reports. Claimant has also submitted the treatment records attached to Dr. Lenkey's deposition. They consist of a July 2005 x-ray interpretation, a February 2005 pulmonary function test, and CT scans from 2004 and 2005. (EX 10, Exh. 3, 4, 5, 6). The November 2005 PFT referenced by Dr. Lenkey was not included.

(1) The July 11, 2005 x-ray interpretation was from Dr. Kenamond and did not utilize the ILO system; it stated that there was an elevated left hemidiaphragm, and mild increased markings in the left lung base that were likely fibrotic. (EX 10, Exh. 4).

(2) The February 23, 2005 pulmonary function test is discussed above. (EX 10, Exh. 3). A "very good effort" was noted, but insufficient tracings were included. *Id*.

(3) The June 7, 2004 CT scan reading by Kelby L. Frame, M.D. noted in the body of the report the presence of "atelectatic dependent changes posteriorly in both lung bases" as well as visible nodes throughout the mediastinum but no pulmonary mass or discrete noncalcified nodule in either lung field. (EX 10, Exh. 6). It listed the following findings:

1. Slight volume loss in the left lung base with elevation of the left hemidiaphragm and some associated alveolar disease in this region hopefully all related to atelectasis. If there has been symptoms of recurrent pneumonia, hemoptysis or coughing, evaluation of the left lower lobe with bronchoscopy is recommended to exclude endobronchial lesion.
2. No evidence of lung mass or nodule or active alveolar process other than the changes discussed above suspected to relate to atelectasis.
3. No pleural effusion or adenopathy.

(EX 10 Exh. 6). The reading also noted some emphysematous change and no end stage pulmonary fibrotic disease. *Id*.

(4) The February 2, 2005 CT scan report, also by Kelby L. Frame, M.D. reached the following impressions:

1. Volume loss in the left lung bases persists without significant change. And, again, if bronchoscopy has not been performed in the past, it is encouraged to exclude endobronchial process.
2. Suspicion of small interstitial nodular change peripherally in the mid and upper lung fields which may relate to exposural disease. There is a very mild change of emphysema in the upper lungs.
3. No new nodule, mass or adenopathy.

(EX 10, Exh. 5). Once again, there was no end-stage pulmonary fibrosis identified. *Id*.

Discussion

Evidentiary Limitations

My consideration of the medical evidence is limited under the regulations, which apply evidentiary limitations to all claims filed after January 19, 2001. 20 C.F.R. §725.414. Section 725.414, in conjunction with Section 725.456(b)(1), sets limits on the amount of specific types of medical evidence that the parties can submit into the record. *Dempsey v. Sewell Coal Co.*, 21 B.L.R. --, BRB No. 03-0615 BLA (June 28, 2004) (en banc) (slip op. at 3), *citing* 20 C.F.R. §§725.414; 725.456(b)(1). Under section 725.414, the claimant and the responsible operator may each "submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports." *Id., citing* 20 C.F.R. §725.414(a)(2)(i),(a)(3)(i). In rebuttal of the case presented by the opposing party, each party may submit "no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by" the opposing party "and by the Director pursuant to §725.406." *Id., citing* 20 C.F.R. §725.414(a)(2)(ii), (a)(3)(ii). The Benefits Review Board recently ruled that §725.414(a)(ii) permits a party to submit rebuttal evidence which contradicts the opposing party's case, even if it does not contradict the specific item of evidence to which it is responsive. *Sprague v. Freeman United Coal Mining Co*., BRB No. 05-1020 BLA, (BRB Aug. 31, 2006) (per curiam) (unpub.) (slip. op. at 6). Of course, the evidence submitted must still be within the evidentiary limits. *Id*.

Following rebuttal, each party may submit "an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing," and, where a medical report is undermined by rebuttal evidence, "an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence." *Id.* "Notwithstanding the limitations" of section 725.414(a)(2),(a)(3), "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence." *Id., citing* 20 C.F.R. §725.414(a)(4). Medical evidence that exceeds the limitations of Section 725.414 "shall not be admitted into the hearing record in the absence of good cause." *Id. citing* 20 C.F.R. §725.456(b)(1). The parties cannot waive the evidentiary limitations, which are mandatory and therefore not subject to waiver. *Phillips v. Westmoreland Coal Co.*, 2002-BLA-05289, BRB No. 04-0379 BLA (BRB Jan. 27, 2005) (unpub.) (slip op. at 6).

The Benefits Review Board discussed the operation of these limitations in its en banc decision in *Dempsey, supra.* First, the Board found that it was error to exclude CT scan evidence because it was not covered by the evidentiary limitations and instead could be considered "other medical evidence." *Dempsey* at 5; see 20 C.F.R. § 718.107(a) (allowing consideration of medical evidence not specifically addressed by the regulations). However, in *Webber v. Peabody Coal Co,* 23 B.L.R. 1-__, BRB No. 05-0335 BLA (Jan. 27, 2006) (en banc), the Board changed the position that it took in *Dempsey* with respect to CT scan evidence and adopted the Director's position that "the use of singular phrasing in 20 C.F.R. § 718.107" requires "only one reading or

interpretation of each CT scan or other medical test or procedure to be submitted as affirmative evidence." Second, the Board found that it was error to exclude pulmonary function tests and arterial blood gases derived from a claimant's medical records simply because they had been proffered for the purpose of exceeding the evidentiary limitations. *Dempsey* at 5. Third, the Board held that state claim medical evidence is properly excluded if it contains testing that exceeds the evidentiary limitations at § 725.414. In so holding, the Board noted that such records did not fall within the exceptions for hospitalization or treatment records or for evidence from prior federal black lung claims. *Dempsey* at 5. Fourth, on the issue of good cause for waiver of the regulations, the Board noted that a finding of relevancy would not constitute good cause and therefore records in excess of the limitations offered on that basis, and on the basis that the excluded evidence would be "helpful and necessary" for the reviewing physicians to make an accurate diagnosis, were properly excluded. *Dempsey* at 6. Finally, the Board stated that inasmuch as the regulations do not specify what is to be done with a medical report that references inadmissible evidence, it was not an abuse of discretion to decline to consider an opinion that was "inextricably intertwined" with excluded evidence. *Dempsey* at 9. Referencing *Peabody Coal Co. v. Durbin*, 165 F.3d 1126, 21 B.L.R. 2-538 (7th Cir. 1999), the Board acknowledged that it was adopting a rule contrary to the common law rule allowing inadmissible evidence to be considered by a medical expert, because "[t]he revised regulations limit the scope of expert testimony to admissible evidence." *Dempsey* at 9-11.

In *Brasher v. Pleasant View Mining, Inc.*, BRB No. 05-0570 BLA (BRB April 28, 2006), slip op. at 6, the Board noted that, where a physician's reports constitute two separate written assessments of the miner's pulmonary condition at two different times, an administrative law judge may properly decline to consider them as a single medical report under the evidentiary limitations.

In its post-hearing brief, Employer has argued that it should be allowed to submit two interpretations of the September 18, 2002 DOL x-ray in response to the interpretations by Drs. Noble and Ahmed. Employer's Post-Hearing Brief at 4-5. Employer has already designated the interpretation of Dr. Wheeler, but now seeks to also have Dr. Scott's interpretation designated as evidence. Brief at 4-5.

Employer argues that the Fourth Circuit's decision in *Elm Grove Coal Co. v. Director, OWCP*, 480 F.3d 278 (4th Cir. 2007), allows an opportunity for "piece for piece" rebuttal. Brief at 4. The specific section of the panel's opinion Employer relies on does not support its position. The claimant in *Elm Grove* submitted two interpretations of an October 2002 film as affirmative evidence. *Elm Grove*, 480 F.3d at 298. As rebuttal, Employer sought to submit two interpretations, one for each interpretation of the October 2002 film. *Id*. The administrative law judge interpreted §725.414(a)(3)(ii) to mean that a party seeking to rebut two interpretations of the same film could only submit one interpretation in rebuttal. *Id*. Considering this position, the panel stated:

> Having fully considered this contention, we conclude that §725.414(a)(3)(ii) of the Evidence-Limiting Rules and the identical language found in §725.414(a)(2)(ii) thereof, authorize the submission of one piece of evidence on rebuttal *for each piece of affirmative evidence submitted by the other party*.

Elm Grove, 480 F.3d at 298 (citing 65 Fed. Reg. at 79922) (quotation omitted) (emphasis added). The panel then cited, with approval, to a BRB decision wherein the Board authorized parties to submit one piece of evidence for each piece of *affirmative* evidence offered by the opposing party. *Id*. at 298-299 (citing *Ward v. Consolidation Coal Co*., BRB No. 05-0595 BLA (Mar. 28, 2006). The *Elm Grove* panel subsequently vacated the Board's opinion, which had upheld the administrative law judge's position. *Id*. at 299.

Employer's reliance on *Elm Grove* is misplaced because the panel made quite clear that parties would be permitted to submit rebuttal evidence as long as it was in response to affirmative evidence. With respect to the September 18, 2002 film, the only affirmative evidence submitted came from the district director (Dr. Noble's interpretation). The interpretations of Dr. Ahmed and Dr. Wheeler are both rebuttal to Dr. Noble's interpretation; thus, both parties have already submitted their evidence in response to this piece of affirmative evidence. The interpretation of Dr. Scott would be either another rebuttal of Dr. Noble's interpretation, which is not permitted, or a rebuttal to Claimant's rebuttal, which is also not permitted. Employer may not submit another interpretation merely because the interpretations of Dr. Noble and Dr. Ahmed do not support its position. Thus, I do not accept Dr. Scott's interpretation of the September 18, 2002 film, and it will remain stricken.

As a final matter, I will consider the extent to which an expert may have relied upon inadmissible evidence in formulating his or her opinion when weighing the evidence. To the extent not inextricably intertwined with the inadmissible evidence, the expert witness opinion will be considered. This principle is of significance in considering the opinions of the reviewing physicians who relied in part upon their own interpretations of the x-rays taken during the examination they performed. It will be discussed as applicable below.

The record is otherwise in evidentiary compliance. This is the first claim filed by Claimant so there are no previous claims of record.

Medical Issues

To prevail in a claim for Black Lung benefits, a claimant must establish that he or she suffers from pneumoconiosis; that the pneumoconiosis arose out of coal mine employment; that he or she is totally disabled, as defined in section 718.204; and that the total disability is due to pneumoconiosis. 20 C.F.R. §§718.202 to 718.204. The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. In *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994), the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants. Thus, in order to prevail in a black lung case, the claimant must establish each element by a preponderance of the evidence. If complicated pneumoconiosis is established, all of the necessary elements of a claim are presumptively established under the irrebuttable presumption set forth in 30 U.S.C. ' 921(c)(3) and 20 C.F.R. '718.304. As Claimant has not submitted evidence suggesting the presence of complicated pneumoconiosis, I must determine whether Claimant has established all of the elements of entitlement, starting with pneumoconiosis.

Existence of Pneumoconiosis

The regulations (both in their original form and as revised effective January 19, 2001) provide several means of establishing the existence of pneumoconiosis: (1) a chest x-ray meeting criteria set forth in 20 C.F.R. §718.102, and in the event of conflicting x-ray reports, consideration is to be given to the radiological qualifications of the persons interpreting x-ray reports; (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. §718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" set forth in 20 C.F.R. §718.304 (or two other presumptions set forth in §718.305 and §718.306); or (4) a determination of the existence of pneumoconiosis as defined in §718.201 made by a physician exercising sound judgment, based upon objective medical evidence and supported by a reasoned medical opinion. 20 C.F.R. §718.202(a) (1)-(4). Under section 718.107, other medical evidence, and specifically the results of medically acceptable tests and procedures which tend to demonstrate the presence or absence of pneumoconiosis, may be submitted and considered. As this case arises in the Fourth Circuit, all of the evidence from section 718.202 should be weighed together in determining whether a miner suffers from pneumoconiosis. *See, e.g., Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-209 (4th Cir. 2000). *But see Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc) (noting "the Sixth Circuit has often approved the independent application of the subsections of Section 718.202(a) to determine whether claimant has established the existence of pneumoconiosis.")

Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149 (1989) (en banc); *Casella v. Kaiser Steel Corp*., 9 B.L.R. 1-131 (1986).

In the December 2000 amendments to the regulations, the definition of pneumoconiosis in section 718.201 was amended to provide for "clinical" and "legal" pneumoconiosis and to acknowledge the latency and progressiveness of the disease. Clinical pneumoconiosis consists of those diseases recognized by the medical community as pneumoconiosis, such as coal worker's pneumoconiosis or silicosis. Legal pneumoconiosis is defined as "any chronic lung disease or impairment and its sequelae arising out of coal mine employment." 20 C.F.R. §718.201(a). The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. §718.201(b).

X-ray evidence. Claimant has established by a preponderance of the x-ray evidence that he has pneumoconiosis. The x-ray evidence of record that has been designated by the parties is summarized above. Under 20 C.F.R. §718.202(a)(1), when x-ray reports conflict, I am required to weigh the qualifications of the experts. I may also accord greater weight to more recent studies. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc). Having reviewed the chest x-ray interpretation evidence based upon the July 20, 2001, September 18, 2002,

September 24, 2002, and April 17, 2003 films, and having taken into consideration the qualifications of the readers, I find it is positive for the existence of pneumoconiosis:

(1) The July 20, 2001 film (taken during Dr. Lenkey's exam) was interpreted by Drs. Noble and Meyer, both of whom are dually qualified as B-readers and board-certified radiologists. (DX 22, EX 2). Dr. Noble (who used the ILO classification but did not use the ILO form) found that this film showed "s/t opacifications" of 1/0 profusion in the lower lung zones bilaterally, with more on the left; his report is therefore positive for pneumoconiosis. (DX 22). By contrast, Dr. Meyers indicated on the ILO form that he did not find any parenchymal or pleural abnormalities consistent with pneumoconiosis, and in a supplemental report indicated that there was no radiographic evidence of coal workers' pneumoconiosis (although there was a bibasilar air space opacity reflecting atelectasis or scarring). (EX 2). His report is therefore negative for pneumoconiosis. Regardless of each physician's findings, since both are equally qualified, their interpretations are in equipoise. Therefore, this film is not evidence for or against the existence of pneumoconiosis.

(2) The September 18, 2002 film, taken as part of the DOL exam, was interpreted by three board-certified radiologists who are B-readers as well: Dr. Noble (DX 20); Dr. Ahmed (CX 1); and Dr. Wheeler (DX 26). Briefly restated, Drs. Noble and Ahmed found the film showed evidence of pneumoconiosis (1/0, s/t, two lower zones and 1/1, p/q, all six zones, respectively), whereas Dr. Wheeler did not. Although all three physicians are equally qualified, two of them found the presence of pneumoconiosis while one did not. I therefore conclude that the preponderance of the evidence demonstrates that this film is positive for the existence of pneumoconiosis.

(3) The September 24, 2002 film (taken during Dr. Altmeyer's exam) was interpreted by Drs. Meyer and Ahmed, who are both B-readers and board-certified radiologists. (EX 2, CX 3). Although Dr. Meyer found nodular opacities, as well as the bibasilar air space opacity described above, he marked the boxes indicating there were no parenchymal or pleural abnormalities consistent with pneumoconiosis (EX 2). Dr. Ahmed found parenchymal opacities consistent with pneumoconiosis (1/1, p/q, all six zones) (CX 3). Because both are equally qualified, the interpretations are in equipoise, and do not support the existence or non-existence of pneumoconiosis.

(4) The April 17, 2003 film (taken during Dr. Fino's exam) was also interpreted by Drs. Meyer and Ahmed. (EX 2, CX 2). Again, Dr. Meyer noted the bibasilar air space disease but did not find the presence of coal workers' pneumoconiosis, or abnormalities suggesting pneumoconiosis (EX 2); Dr. Ahmed found opacities consistent with pneumoconiosis, (1/1, p/q, all six zones) (CX 2). Because of their equal qualifications, these interpretations are in equipoise.

Of the above four films, three are in equipoise and neither support nor undermine a finding of pneumoconiosis. However, the September 18, 2002 film is positive for pneumoconiosis, and no reason has been presented why its probative value should be discounted. I therefore conclude that the x-ray evidence is positive for the existence of pneumoconiosis.

Biopsy Evidence. As there is no biopsy evidence of record, Claimant has failed to establish the presence of the disease under 20 C.F.R. §718.202(a)(2).

Complicated Pneumoconiosis and Other Presumptions. A finding of opacities of a size that would qualify as "complicated pneumoconiosis" under 20 C.F.R. §718.304 results in an irrebuttable presumption of total disability. As there is no evidence of complicated pneumoconiosis, the section 718.304 presumption is inapplicable. The additional presumptions described in section 718.202(a)(3), which are set forth in 20 C.F.R. §718.305 and 20 C.F.R. §718.306, are also inapplicable, inter alia, because they do not apply to claims filed after January 1, 1982 or June 30, 1982, respectively, and section 718.306 only applies to death claims. Thus, Claimant has failed to establish the presence of pneumoconiosis under 20 C.F.R. §718.202(a)(3).

Medical Opinions. For the reasons I set forth below, I conclude that the medical opinion evidence supports a finding that Claimant suffers from pneumoconiosis.

The medical opinions are summarized in detail above. Essentially, Dr. Attila Lenkey, Claimant's treating physician, found the Claimant to be suffering from coal workers' pneumoconiosis, or clinical pneumoconiosis, and ultimately found legal pneumoconiosis as well; Dr. Melvin Saludes, the DOL examiner, found him to be suffering from both clinical (medical) and legal pneumoconiosis; and Dr. Robert Altmeyer and Dr. Gregory Fino found that he did not have either clinical or legal pneumoconiosis.

Factors to be considered when evaluating medical opinions include the reasoning employed by the physicians and the physicians' credentials. *See Millburn Colliery Co. v. Hicks***,** 138 F.3d 524, 536 (4th Cir. 1998). A doctor's opinion that is both reasoned and documented, and is supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis, and a "reasoned" opinion is one in which the underlying documentation is adequate to support the physician's conclusions. *Fields, supra.* In addition, the regulation appearing at 20 C.F.R. §718.104(d) (added in December 2000) allows additional weight to be given to the opinion of a treating physician but requires certain factors, including the nature and duration of the relationship, the frequency of treatment, and the extent of treatment, to be considered.

At the outset, I note that each of the four physicians is highly qualified to express an opinion in this case, as each is board-certified in internal medicine and the subspecialty of pulmonary medicine. Furthermore, each practices in the area of pulmonary medicine. I do not find a basis for assigning more weight to the opinion of one of these physicians over the others on the basis of credentials. Accordingly, I will consider the reasoning and clinical support for the opinions.

Dr. Lenkey expressed two well-reasoned opinions, and I find the second opinion in particular, as expressed in a report and explained at a deposition, to be entitled to significant weight. The first opinion was based upon a single examination, including the x-ray interpretation by a dually qualified reader, made in connection with a worker's compensation

case. The second, rendered five years later, was based upon a later examination, interpretation of x-rays taken at that time, and five years of treating the Claimant on a frequent (about four times yearly) basis for pulmonary complaints. Dr. Lenkey explained the basis for his opinions at his two depositions. While Dr. Lenkey is somewhat unclear about his use of the term "coal workers pneumoconiosis," which he appears at times to use synonymously with "pneumoconiosis," he has fully explained the basis for his opinions at his depositions. His opinions are summarized above. I find both opinions to be well reasoned and documented and therefore entitled to significant weight.

Furthermore, I find that the second opinion is entitled to special consideration because of Dr. Lenkey's status as a treating physician who treated the Claimant for his pulmonary problems (specifically, occupational lung disease and chronic bronchitis) three to four times yearly over a five-year period. While I understand that I cannot mechanistically give additional weight to a treating physician's opinion (*see, e.g., Consolidation Coal Co. v. Held,* 314 F.3d 184, 187, 22 BLR 2-264, 2-571 (4th Cir. 2002)), the regulation appearing at 20 C.F.R. §718.104(d) must have some meaning. In adopting the rule, the Department stated the following:

> The rule's purpose is to recognize that a physician's professional relationship with the miner may enhance his insight into the miner's pulmonary condition. A treating physician may develop a more in-depth knowledge and understanding of the miner's respiratory and pulmonary condition than a physician who examines the miner only once or who reviews others' examination reports. Section 718.104(d) is not an outcome-determinative evidentiary rule, however. It does not preclude consideration of other relevant evidence of record. Rather, it provides criteria for evaluating the quality of the doctorpatient relationship. The criteria at § 718.104(d)(1)–(4) are indicia of the potential insight the physician may have gained from on-going treatment of the miner. The rule is designed to force a careful and thorough assessment of the treatment relationship. If the adjudicator concludes the treating physician has a special understanding of the miner's pulmonary health, that opinion may receive ''controlling weight'' over contrary opinions. That determination may be made, however, only after the adjudicator considers the credibility of the physician's opinion in light of its documentation and reasoning and the relative merits of the other relevant medical evidence of record.

65 Fed. Reg. 79923 (Dec. 20, 2000). Given the strong support by the factors set forth in that section, coupled with the diagnostic issues in the instant case, I find that Dr. Lenkey's opinion is entitled to additional weight due to the enhanced insight that he gained during the period of time that he treated the Claimant.

Dr. Saludes' opinion was based upon the single DOL examination, including the x-ray interpretations taken at that time. Although his report was essentially conclusory in nature, he explained his opinions more fully at his deposition. He was only deposed that one time and did not have the opportunity to discuss the 2004 and 2005 CT scan evidence, and his opinion is entitled to diminished weight as a result. However, I find his opinion to be well reasoned and entitled to some weight on that basis. In addition, it is corroborative of Dr. Lenkey's opinion.

Both Dr. Fino and Dr. Altmeyer based their opinions upon a single examination; however, they also reviewed other records and also reviewed the x-rays taken during their examinations. They were each deposed twice, with the second deposition taken after they reviewed Dr. Lenkey's treatment records. Dr. Fino's opinion changed somewhat during the second examination. Both opinions are based in significant part upon their conclusions that the x-ray evidence is negative for pneumoconiosis when I have reached the opposite conclusion. The opinions are entitled to less weight on that basis.

Along similar lines, the opinions of Dr. Fino and Dr. Altmeyer both lose probative weight because they relied extensively on evidence that is inadmissible – specifically, their own interpretations of the x-rays taken during their examinations that have not been designated by either party and exceed the evidentiary limitations; and, in the case of Dr. Fino, his own interpretation of a CT scan. With respect to Dr. Fino, his written report only takes into account his own interpretation of the x-ray taken as part of his examination of Claimant. Dr. Fino also relied heavily upon the same interpretation in his first deposition, although he reviewed several other interpretations as well. Dr. Altmeyer relied upon his own interpretation of the x-ray taken as part of his examination in both his written report and his first deposition. Both doctors said their respective interpretations showed irregular shaped opacities in the lower zones, which was not indicative of coal workers' pneumoconiosis. Dr. Fino went further and stated that his interpretation, along with the others he reviewed, demonstrated that Claimant was actually suffering from idiopathic pulmonary fibrosis. In his second deposition, he opined that the CT scan ruled out the presence of coal worker's pneumoconiosis or fibrosis; however, the CT scan interpretation itself (summarized above) did not, so he is relying upon his own interpretation. It is therefore clear that both physicians relied extensively upon their own inadmissible interpretations to conclude that Claimant was not suffering from coal workers' pneumoconiosis.

While Drs. Lenkey and Saludes, neither of whom is a B-reader, also reviewed x-rays, a fair reading of their reports and depositions makes it clear that they relied upon the interpretations by the dually qualified readers of the x-rays rather than their own interpretations. Moreover, they relied upon positive interpretations, and I have found the x-ray evidence to be positive.

There are two additional factors relating to Dr. Fino's opinion that lead me to assign it less weight. These factors, while not as significant as the other factors mentioned above, nevertheless merit mentioning.

First, even if I were to accept Dr. Fino's own x-ray interpretation, his method of interpreting chest x-rays is questionable. Dr. Fino testified that when he did readings of chest x-rays he would take into account other clinical information in determining what classification to assign it. (EX 8 at 12). Dr. Fino acknowledged that the ILO system was designed to offer blind readings of the film only, but that as a physician, he could not ignore clinical evidence presented to him. (EX 8 at 12-13). He also acknowledged that the ILO system contains a broad definition of pneumoconiosis which encompasses other abnormalities besides coal workers' pneumoconiosis, yet he did not believe his interpretation, or the other interpretations he reviewed, showed coal workers' pneumoconiosis. (EX 8 at 13). In fact, he even acknowledged

that there could be many other forms of pneumoconiosis which could appear in the lower lung zones, although coal workers' pneumoconiosis would not first appear in the lower lung zones. (EX 8 at 14). Thus, although Dr. Fino acknowledged pneumoconiosis is a broad category, he limited his opinion solely to coal workers' pneumoconiosis. Given these circumstances, Dr. Fino's opinion loses further weight.

Second, Dr. Fino's opinion also loses probative weight because his final conclusion, expressed at his second deposition, that Claimant's obesity is the cause of his restrictive impairment is not well-reasoned. Initially, Dr. Fino concluded that Claimant was suffering from idiopathic pulmonary fibrosis, and that this disease was the cause of Claimant's restrictive impairment. When questioned during his first deposition whether obesity could be the sole cause, Dr. Fino testified that it was possible, but felt that there was more to Claimant's restriction than obesity. When confronted with the results of the 2005 CT scan, Dr. Fino admitted in his subsequent deposition that not enough fibrosis was present for a diagnosis of idiopathic pulmonary fibrosis. However, relying upon that fact the CT scan showed an elevated hemidiaphragm, Dr. Fino concluded that obesity was the sole cause of Claimant's restriction. He made no attempt to clarify his previous position that something more than obesity was involved with Claimant's restriction. Indeed, when confronted with the CT scan's finding of nodular infiltrates that could be indicative of occupational exposure, Dr. Fino refused to consider a diagnosis of coal workers' pneumoconiosis, emphasizing that the CT scan was only suspicious of nodular infiltrates. Thus, Dr. Fino's change in position is not sufficiently reasoned. To be sure, Dr. Fino's decision to change his diagnosis of idiopathic pulmonary fibrosis after reviewing objective evidence, i.e., the CT scan, is not problematic in itself. However, given his initial conclusion that Claimant's restriction was primarily due to some other etiology than obesity, his decision to fully embrace obesity as the sole cause in his second deposition warrants further explanation, which is lacking. As a result, Dr. Fino's conclusions lose probative value.

Claimant also argues that the opinions of Drs. Altmeyer and Fino should be accorded less probative weight because of the amount of fees paid to them by Employer for other matters they were involved in. Employer contends the amount of fees paid to each expert has no relevance in assessing their credibility. I conclude that while the amount paid to each physician is indeed relevant, the evidence presented does not lessen the weight to which each physician's opinion is entitled.

The evidence proffered by Claimant is clearly relevant as it goes to the credibility and potential bias of Employer's experts. The United States Court of Appeals for the Fourth Circuit, where this matter arises, has instructed administrative law judges in black lung claims, when weighing expert witness testimony, to take into consideration an expert's "freedom from irrelevant distractions and prejudice" and "whether an opinion was, to any degree, the product of bias in favor of the party retaining the expert and paying the fee." *See Underwood v. Elkay Mining, Inc.*, 105 F.3d 946, 951 (4th Cir. 1997), *superseded on other grounds by rule*, *Elm Grove Coal Co. v. Director, OWCP*, 480 F.3d 278 (4th Cir. 2007).[21] The Fourth Circuit has also noted that experts in black lung claims, like experts in any other litigation, have the potential to be

[21] The Fourth Circuit recognized in *Elm Grove* that the discussion of the admissibility of evidence in Black Lung cases in *Underwood* was superseded by the regulations setting forth evidentiary limitations, which were entitled to deference under *Chevron v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

biased. *Consolidation Coal Co. v. Williams*, 453 F.3d 609, 619 (4th Cir. 2006). As Judge Hall of the Fourth Circuit stated, "[d]isability, or the lack thereof, seems inevitably in the eye of the paid beholder." *Grizzle v. Picklands Mather and Co./Chisolm Mines*, 994 F.2d 1093, 1101 (4th Cir. 1993) (Hall, J., dissenting). Thus, how often a physician testifies for a particular party, and the amount of compensation, is entirely relevant to assessing the credibility of that physician's findings.[22] However, by the same token, the Benefits Review Board has held that an expert's affiliation with a party, standing alone, is not grounds to disqualify that expert's opinion. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (en banc).

Employer's counsel examined its own records through the year 2000-2005, and contacted other law firms that had retained the services of Drs. Fino and Altmeyer for those same years, to see how many times Employer had utilized these physicians' services and how much they were paid. According to the information obtained, between the years 2000 and 2005, Dr. Altmeyer offered his services for Employer in 50 separate claims for a total of $42,999.00. (CX 7). For the years 2000 through part of 2004, Dr. Fino was employed at South Hill Pulmonary Associates ("South Hill"); for part of 2004 through 2005, Dr. Fino was employed at Clinical & Occupational Medicine Associates ("Medicine Associates"). *Id*. Dr. Fino was referred 116 claims while employed at South Hill, and 35 claims while at Medicine Associates for a total amount of $150,049.50. *Id*.

Employer asserted that some of the amount paid to Dr. Fino went to test costs (e.g., pulmonary function tests, arterial blood gas studies). *Id*. The South Hill records show only two entries for "medical tests": 03/10/03, $50; 12/26/02, $387. *Id*. The Pulmonary Associates records list the following tests: 07/28/04, PFT and ABG, $331.67 for each; 10/22/03, medical tests, $1,680; 5/20/04, ABG, $1,060; 08/14/03, medical tests, $662. *Id*. These tests amount to $4,502.34, which reduces the amount paid to Dr. Fino to $145,547.16.

Notwithstanding the above, I do not find that the amounts paid to Drs. Altmeyer and Fino reduce the probative value of their opinions. The amounts shown in the records produced are not so high or shocking as to demonstrate any sort of significant influence on the opinions of each physician. Both physicians are entitled to compensation for their unique services and each has impressive credentials. The amount paid, as demonstrated by the evidence of record, simply does not show an influence over the physicians by Employer through financial means.

Based on the above conflicting evidence, I conclude that the medical opinion evidence supports a finding that Claimant suffers from both clinical and legal pneumoconiosis. Specifically, I find that the opinions by Dr. Lenkey and Dr. Saludes, considered together, establish that Claimant suffers from both clinical and legal pneumoconiosis, and the opinions of Drs. Fino and Altmeyer are entitled to less weight due to the factors set forth above.

Other Records. Claimant submitted a July 11, 2005 x-ray interpretation, a February 2005 pulmonary function test, and CT scan hospital reports from 2004 and 2005 (attached as exhibits to Dr. Lenkey's May 15, 2006 deposition) (EX 10, Exh. 3, 4, 5, 6). While the pulmonary function tests are of use in assessing degree of impairment and may be utilized by

[22] The Fourth Circuit has also explicitly held that information concerning bias of an expert witness in a black lung claim is discoverable. *E.g., Consolidation Coal Co. v. Williams*, 453 F.3d 609, 620-21 (4th Cir. 2006).

expert witnesses in formulating their opinions concerning the appropriate diagnosis, in and of themselves they are not of probative value on the pneumoconiosis issue. Likewise, as the July 11, 2005 x-ray was not interpreted in accordance with the ILO system, it is not of significant value in determining whether the Claimant has pneumoconiosis.

Similarly, as the ILO system has not been utilized, the CT scan interpretations are of limited value. Although I am not persuaded that the CT scans are negative for pneumoconiosis, they are not particularly probative of its existence either. In this regard, the 2004 CT scan report, despite noting abnormalities, did not note findings indicative of occupational disease, while the 2005 CT scan report only suggested occupational disease as a possibility. (EX 10 Exh. 5, 6). Specifically, the February 2005 CT scan interpretation noted the presence of suspected nodular infiltrates in the mid, and possible upper, left lung zones. *Id*. The report further stated that this could relate to an exposural disease (i.e., occupational lung disease) and did not mention other possible explanations. *Id*. However, there was no mention of coal workers' pneumoconiosis, silicosis, or pneumoconiosis in general. Moreover, from this interpretation it is not clear whether the opacities were of a profusion or distribution that would qualify as pneumoconiosis under the regulations, and an occupational etiology, while suggested, was not stated to a degree of medical certainty. Considering the CT scan evidence, Dr. Lenkey found it to be supportive of a finding of pneumoconiosis while Drs. Altmeyer and Fino did not. However, none of them are radiologists. In short, I find that the CT scans neither support nor undermine a finding of pneumoconiosis.

All Evidence on Pneumoconiosis. Taking into consideration all the evidence submitted on the issue of the existence of pneumoconiosis, I conclude that Claimant has established by a preponderance of the evidence that he is suffering from both clinical and legal pneumoconiosis, based upon the x-ray evidence and medical opinion evidence considered along with the other evidence of record.

Causal Relationship of Pneumoconiosis with Coal Mine Employment.

Even though Claimant has established that he is suffering coal workers' pneumoconiosis, he must prove by a preponderance of the evidence that his pneumoconiosis arose from his coal mine employment. Under 20 C.F.R. §718.203(b), if a claimant establishes that he has pneumoconiosis and also establishes at least 10 years of coal mine employment in one or more coal mines, he is entitled to a rebuttable presumption that his pneumoconiosis arose from coal mine employment.

As the parties stipulated to 32 years of coal mine employment and I have found that Claimant has pneumoconiosis, Clamant may take advantage of the rebuttable presumption afforded to him by section 718.203. Employer has not rebutted the presumption that Claimant has pneumoconiosis which arose from coal mine employment. Since I have concluded he has clinical pneumoconiosis, and he has over 10 years of coal mine employment, I conclude that Claimant's pneumoconiosis arose from his coal mine employment. Moreover, the medical opinion evidence (discussed above) also supports that conclusion with respect to both clinical and legal pneumoconiosis. Claimant has therefore established causal relationship both presumptively and directly.

Total Disability

A claimant must establish total disability due to pneumoconiosis in order to be eligible for benefits under the Act. *See Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). It is well established that even a moderate or mild pulmonary or respiratory impairment may constitute total respiratory disability, provided that the impairment precludes further coal mine employment. *See, e.g., Cornett v. Benham Coal Co.*, 227 F.3d 569, 577-78, 22 B.L.R. 2-107 (6th Cir. 2000); *Carson v. Westmoreland Coal Co.*, 19 B.L.R. 1-16 (1964), *modified on recon*. 20 B.L.R. 1-64 (1996). Disability may also be established presumptively if the miner suffers from complicated pneumoconiosis. *See* 30 U.S.C. §921(c)(3); 20 C.F.R. §718.304.

The regulations as amended provide that a claimant can establish total disability by showing pneumoconiosis prevented the miner "[f]rom performing his or her usual coal mine work," and "[f]rom engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." 20 C.F.R. §718.204(b)(1). Where, as here, there is no evidence of complicated pneumoconiosis, total disability may be established by pulmonary function tests, arterial blood gas tests, evidence of cor pulmonale with right sided congestive heart failure, or physicians' reasoned medical opinions, based on medically acceptable clinical and laboratory diagnostic techniques, to the effect that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in the miner's previous coal mine employment or comparable work. 20 C.F.R. §718.204(b)(2). For a living miner's claim, it may not be established solely by the miner's testimony or statements. 20 C.F.R. §718.204(d)(5). Claimant's job description must be considered in light of the medical evidence.

Pulmonary Function Tests. Under subparagraph (i), total disability is established if the FEV1 value is equal to or less than the values set forth in the pertinent tables in 20 C.F.R. Part 718, Appendix B, for the miner's age, sex and height, if, in addition, the tests reveal qualifying FVC or MVV values under the tables, or an FEV1/FVC ratio of less than 55%.

The four pulmonary function tests designated as evidence (summarized above) produced qualifying values. (DX 17, 22, 24; EX 3). The additional test from the medical records (EX 10) does not satisfy the quality standards and will not be considered. I therefore conclude that that the pulmonary function tests support a finding of total disability.

Arterial Blood Gas Studies. Under subparagraph (ii) of 20 C.F.R. § 718.204(b)(2), total disability is established if the arterial blood gases show the values set forth in the pertinent tables in 20 C.F.R. Part 718, Appendix C for the appropriate altitude.

The arterial blood gas studies of record did not include exercise values; however, all the resting values qualify.[23] (DX 17, 22, 24; EX 3). . I therefore conclude that the arterial blood gas study evidence supports a finding of total disability.

[23] Evidence in the record demonstrates that Claimant had been on oxygen since either August or September of 2001 but it is unclear whether he was on his oxygen during the administration of the ABG tests.

Cor pulmonale with right-sided congestive heart failure. A claimant may establish total disability if he or she can establish cor pulmonale with right sided congestive heart failure. 20 C.F.R. §718.204(b)(2)(iii). Dr. Lenkey concluded that Claimant was suffering from cor pulmonale (mistranscribed as "chronic pulmonale.") (DX 22, DX 25 at 30-31). In neither his report nor his deposition, did Dr. Lenkey explain the basis for his diagnosis. Furthermore, in his subsequent report and deposition, CX 5 and EX 10, respectively, Dr. Lenkey made no mention of cor pulmonale. Dr. Fino testified that he did not see any objective evidence which would justify a diagnosis of cor pulmonale. (EX 8 at 21). Furthermore, there has been no diagnosis of any form of congestive heart failure. I therefore conclude that Claimant has not established that he is suffering from cor pulmonale with right sided congestive heart failure.

Medical opinion evidence on total disability. A claimant may also establish total disability through reasoned medical opinion evidence. Based on a review of the medical reports and depositions of record, I conclude that the medical opinion evidence supports a finding of total disability.

All four physicians who examined Claimant agreed that he is suffering from a respiratory disability that would prevent him from returning to his previous coal mining duties. (DX 17, DX 22, DX 24, EX 3). Drs. Saludes, Lenkey, and Fino were all fairly clear on the fact that Claimant was unable to return to his previous coal mining duties based upon his pulmonary or respiratory condition, as discussed above. Dr. Altmeyer was slightly less clear. Specifically, in his written report, he wrote:

> It is my opinion that [Claimant] is not totally and permanently disabled to such an extent that he would be unable to perform his regular coal mine job or a job requiring a similar degree of effort or exertion from any pulmonary or respiratory disease or impairment *from working at coal mines*. He does, however, have a significant combined obstructive and restrictive impairment of lung function which would likely prove disabling from the last jobs in the coal mine, as he described to me, or jobs requiring a similar degree of effort or exertion. This impairment is not occupationally related. [Emphasis added.]

(DX 24). Although at first blush, Dr. Altmeyer appears to say that Claimant has no pulmonary or respiratory disability, he actually clarifies that Claimant does have a lung impairment that would stop Claimant from returning to coal mining duties. However, Dr. Altmeyer is of the opinion that this disability was not caused by Claimant's coal mine employment. Dr. Altmeyer's opinion is nevertheless sufficient to support a finding of total disability.

After reviewing all of the above evidence, I find that Claimant is totally disabled from a pulmonary or respiratory standpoint from returning to his previous coal mining duties. Quite simply, after having reviewed his description of his work as a mechanic, which required heavy lifting, coupled with the test results and medical opinions, I find that he is incapable of performing that job or a comparable job in a dust free environment based upon his pulmonary or respiratory condition alone.

Causation of Total Disability

After establishing that a miner is totally disabled, a claimant must still establish that the miner's total disability was caused at least in part by his or her coal mine employment. 20 C.F.R. §718.204(a). If the presumptions are not available to a claimant, that claimant must prove the etiology of the disability by a preponderance of the evidence, even if he or she has proven the existence of total disability. *See Tucker v. Director,* 10 B.L.R. 1-35, 1-41 (1987). As amended, the regulations require a claimant to prove that pneumoconiosis is a "substantially contributing cause" to the miner's total disability. 20 C.F.R. § 718.204(c)(1). The regulations define "substantially contributing cause" as follows:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. § 718.204(c)(1). In making this determination, the finder-of-fact must not take into account any non-pulmonary or non-respiratory impairments a miner may have, unless said condition causes a chronic respiratory or pulmonary impairment. 20 C.F.R. §718.204(a).

Thus, the amended regulations place an additional burden upon the Claimant to establish a substantial contribution by pneumoconiosis. In this regard, the Department of Labor commented in the preamble to the amended regulations that "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. 79946 (Dec. 20, 2000). However, the amended regulations also allow for a finding of total disability due to pneumoconiosis even when there is another totally disabling respiratory or pulmonary condition if pneumoconiosis has a material adverse effect or materially worsens an unrelated total respiratory or pulmonary disability. *See* 20 C.F.R. §718.204.[24]

The Benefits Review Board had an opportunity to examine this new provision in *Gross v. Dominion Coal Corp.*, 23 B.L.R. 1-10 (2003). In that decision (slip op. at 6 to 7), the Board held that an opinion (by Dr. Forehand) stating that pneumoconiosis was one of two causes of the miner's totally disabling pulmonary condition, but which did not attempt to specify the relative contributions of coal dust exposure and cigarette smoking, was sufficient to satisfy the new standard. The Board found that the doctor's opinion satisfied that "material adverse effect" requirement. The Board also found that substantial evidence supported the administrative law judge's discrediting of the opinion offered by the employer's expert (Dr. Castle) under *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997), which held that an

[24] As noted above, in *National Mining Assn. v. Dept. of Labor*, 292 F.3d. 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit found the portion of 20 C.F.R. § 718.204(a) providing that unrelated nonpulmonary or nonrespiratory conditions causing disability will not be considered in determining whether a miner is totally disabled due to pneumoconiosis to be impermissibly retroactive. The section was otherwise upheld.

administrative law judge should consider the explanation provided by an expert offering an opinion.

However, in its unpublished decision in *Phillips v. Westmoreland Coal Company*, BRB No. 04-0379 BLA (Benefits Review Board Jan. 17, 2005),[25] the Board indicated that under *Gross*, an opinion which stated that pneumoconiosis was one of two causes of a miner's totally disabling pulmonary condition was sufficient (even if it did not attempt to apportion the relative contributions), but that a report that did not address all of the etiological factors for the miner's total respiratory disability was inadequate (even though it stated unequivocally that the Claimant's disability was caused by pneumoconiosis). *Phillips* slip op. at 3 to 4. The Board went on to note that "[a] physician must state the basis for his opinion and explain how the objective data supports his diagnosis in order for his opinion to be considered both documented and reasoned." *Id.*

The opinions of Drs. Altmeyer and Fino regarding the cause of Claimant's disability are not persuasive for several reasons. Chief among them is my conclusion that Claimant has pneumoconiosis, which runs opposite to the conclusions reached by Dr. Fino and Dr. Altmeyer. When a physician bases his or her opinion on conclusions that are opposite those reached by an administrative law judge, that physician's opinion may be accorded less weight. *See Scott v. Mason Coal Co.*, 289 F.3d 263 (4th Cir. 2002). Dr. Fino attempted to circumvent such a result by stating that his opinion regarding the cause of disability would not change even if Claimant were diagnosed with pneumoconiosis. However, this is specious reasoning as Dr. Fino goes to great lengths to explain why he thinks that the Claimant does not have pneumoconiosis. It is clear that Dr. Fino's findings are based on his opinion that Claimant is not suffering from pneumoconiosis.

Dr. Fino's opinions are entitled to diminished weight for additional reasons. As explained above, Dr. Fino did not adequately explain his change of opinion regarding the cause of Claimant's restrictive impairment (i.e., idiopathic pulmonary fibrosis versus obesity). Further, both opinions appear to be based in large part upon his own x-ray interpretations, which are contrary to my findings, and his changed opinion is based upon his own CT scan interpretation, which is inadmissible.

The opinions of both Dr. Fino and Altmeyer are also diminished because of their reliance upon the February 2005 PFT results to conclude that Claimant did not have an obstruction. Dr. Altmeyer admitted that he could not fully conclude whether this specific PFT was valid because only a single tracing was included. (EX 9 at 25). This of course is not in compliance with the standards for PFTs. *See* 20 C.F.R. §718.103. Given that this test cannot be considered fully valid, even though it is admissible as a treatment record, the extent that both physicians relied upon it is problematic.

I also note that Dr. Lenkey, Claimant's treating physician, relied upon a later (November 2005) PFT from the medical records that is not part of the record in this case. Although that test would be admissible as a medical record, it is not part of the record and its probative value as the

[25] The decision is available on the BRB website, which may be accessed via a link from the OALJ website, www.oalj.dol.gov.

basis for Dr. Lenkey's opinion cannot therefore be assessed, entitling that opinion to less weight as well.

Even assuming, arguendo, that the February 2005 PFT were deemed valid, the results produced create some clear contradictions with the opinions of Dr. Fino and Dr. Altmeyer. Dr. Fino continued to find restriction based upon the February 2005 PFT, which he now attributed entirely to obesity. Claimant weighed the exact same weight during Dr. Fino's PFT study as he did during the February 2005 PFT study.[26] Despite this, the FVC value, which Dr. Fino testified is indicative of restriction, actually *decreased*.[27] No explanation was provided for this.

Like Dr. Fino, Dr. Altmeyer believed the improvement in FEV1 values indicated an improved lung function, and also testified that the improvement in FEV1/FVC ratio indicated no significant obstruction. (EX 9 at 18-19). He agreed that the reduced FVC value indicated a restriction. (EX 9 at 25). As did Dr. Fino, he concluded that Claimant's restriction was the result of obesity. (EX 9 at 21). Yet, Dr. Altmeyer did not explain how his 2002 PFT produced higher FVC values than the 2005 PFT, in light of the fact that Claimant actually weighed *more* in 2002 than he did in 2005. *Compare* DX 24 (stating Claimant weighed 208 pounds) *with* EX 10 Exh. 3 (stating Claimant weighed 202 pounds). Like Dr. Fino, he was quick to explain what the difference in FEV1 values indicated, but offered no explanation on what the change in FVC values could indicate.

In contrast to Drs. Altmeyer and Fino, I find that opinions of Drs. Saludes and Lenkey (summarized above) are based upon admissible evidence; however, the value of Dr. Saludes' opinion is undermined by his lack of access to the medical records discussed above (attached to Dr. Lenkey's second deposition) and the weight of Dr. Lenkey's is diminished by his reliance upon a PFT that is not of record. Nevertheless, both physicians considered the etiological factors of cigarette smoke and coal dust exposure and took those factors, and Claimant's obesity, into consideration when determining the cause of Claimant's disability. Their opinions are also consistent with my finding of both clinical and legal pneumoconiosis. As Dr. Fino and Dr. Altmeyer have based their findings of no obstruction based upon the nonconforming PFT, I accept the findings by Dr. Saludes and Lenkey of a mixed obstructive and restrictive defect. Although I have no reason to dispute the assertions raised by Employer's experts that a specific numerical percentage cannot be assigned to coal dust and cigarette smoke, it is clear that Drs. Saludes and Lenkey considered coal dust exposure a significant factor in Claimant's disability. This is sufficient to satisfy *Phillips*.

In view of the above, I find that Claimant has proven by a preponderance of the evidence that his total disability was caused, at least in part, by pneumoconiosis under the regulations as amended.

[26] Claimant weighed 202 pounds.

[27] Indeed, Dr. Altmeyer's September 24, 2002 PFT, performed when Claimant weighed 208 pounds, produced higher FVC values than the February 2005 PFT. (DX 24).

CONCLUSION

Based upon a review of all of the admissible evidence, I find that Claimant has established by a preponderance of the evidence that he is suffering from pneumoconiosis which arose from his coal mine employment. I also find that he has established that his pneumoconiosis, at least in part, caused a totally disabling pulmonary or respiratory impairment that prevents him from returning to his previous coal mining duties or comparable work.

Date of Onset

Under 20 C.F.R. §725.503(b), benefits are payable to a miner beginning with the month of the onset of his total disability. Where the evidence does not establish the date of total disability due to pneumoconiosis, the date of onset may be the month when the claim was filed. 20 C.F.R. §725.503(b).

Claimant has not argued what the date of onset should be and the evidence of record does not provide a clear answer. In this regard, Dr. Lenkey was the first physician to find Claimant to be totally disabled from coal workers pneumoconiosis, and he did so in July 2001. The pulmonary function tests and arterial blood gases were qualifying at that time. Moreover, all of the PFT and ABG tests of record are qualifying. Claimant last worked in the coal mines in August 2000 (albeit with some difficulty), but it is not clear at what point after that he became totally disabled on a respiratory or pulmonary basis. Accordingly, the date of onset shall be the month when the claim was filed, or July 2002.

Attorney's Fee

No award of an attorney's or representative's fee is made herein because no fee application has been received. *See* 30 U.S.C. §932; 33 U.S.C. §928. The Claimant's attorney shall have thirty days for submission of a fee application in conformance with 20 C.F.R. Part 725 and the other parties shall have thirty days to file any objection. These periods may be extended by the stipulation of the parties.

ORDER

IT IS HEREBY ORDERED that the claim of L.P. for black lung benefits under the Act be, and hereby is, **GRANTED** and the Employer/Carrier shall pay the Claimant benefits commencing as of July 1, 2002, with one augmentee, subject to any offset for amounts paid under any state award and to reimbursement of the Trust Fund for amounts previously paid, if applicable.

A

PAMELA LAKES WOOD
Administrative Law Judge

Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207.

Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen H. Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).